

08308

8299

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis,</u>				TOWN <u>Annapolis</u>		19	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
63 <u>Anne Arundel General Hosp.</u>				125 Charles St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>CAROLINE TYSON AITKEN</u>				<u>Sept. 4, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Apr. 18, 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>retired Housewife</u>		<u>At Home</u>		<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Tyson</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Miss Velma Aitken - 125 Charles St.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>24 HRS.</u>			
443x IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cerebrovascular Disease</u>				<u>Unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/2</u> , 19 <u>55</u> , to <u>9/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/3</u> , 19 <u>55</u> , and that death occurred at <u>7:05</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Edward H. Beck</u>				ADDRESS (Street, city, town, state) <u>46 Southgate Ave Annapolis</u>		DATE SIGNED <u>9/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or County) (State)	
<u>Burial</u>		<u>9/7/55</u>		<u>Green Mount Cem.</u>		<u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Sept. 7, 1955</u>		<u>Thm. J. French</u>		<u>Thm. J. Tishner &amp; Sons - Balto</u>		<u>17</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1955

Reg. No. 10

1. Name of deceased (Print or type)

2. Sex (M or F)

3. Date of birth (Month, day, year)

4. Place of birth (City, town, or village)

5. Usual residence (City, town, or village)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Print or type)

9. Place of death (City, town, or village)

10. Signature of attending physician (Print or type)

11. Signature of registrar (Print or type)

12. Signature of informant (Print or type)

13. Signature of medical examiner (Print or type)

14. Signature of coroner (Print or type)

15. Signature of funeral director (Print or type)

16. Signature of undertaker (Print or type)

17. Signature of cemetery (Print or type)

18. Signature of burial place (Print or type)

19. Signature of interment place (Print or type)

20. Signature of final disposition (Print or type)

21. Signature of cremation (Print or type)

22. Signature of other disposition (Print or type)

23. Signature of other disposition (Print or type)

24. Signature of other disposition (Print or type)

25. Signature of other disposition (Print or type)

26. Signature of other disposition (Print or type)

27. Signature of other disposition (Print or type)

28. Signature of other disposition (Print or type)

29. Signature of other disposition (Print or type)

30. Signature of other disposition (Print or type)

31. Signature of other disposition (Print or type)

32. Signature of other disposition (Print or type)

33. Signature of other disposition (Print or type)

34. Signature of other disposition (Print or type)

35. Signature of other disposition (Print or type)

36. Signature of other disposition (Print or type)

37. Signature of other disposition (Print or type)

38. Signature of other disposition (Print or type)

39. Signature of other disposition (Print or type)

40. Signature of other disposition (Print or type)

41. Signature of other disposition (Print or type)

42. Signature of other disposition (Print or type)

43. Signature of other disposition (Print or type)

BUREAU V. B.

SEP 8 1955

RECEIVED

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
 BUREAU OF VITAL RECORDS  
 100 STATE STREET, 10TH FLOOR  
 BOSTON, MASSACHUSETTS 02109  
 (617) 725-1234

8319

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena P.O.</u>		LENGTH OF STAY (in this place) <u>4 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fort Smallwood Road</u>				STREET ADDRESS (If rural give location) <u>Fort Smallwood Road</u>			
3. NAME OF DECEASED: (First) <u>Emma</u> (Middle) <u>C</u> (Last) <u>Algers</u>				4. DATE OF DEATH: (Month) <u>Sept.</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married June 22, 1892</u>		8. DATE OF BIRTH: <u>63</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Samuel</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Fort Smallwood Rd. Pasadena, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Congestive Heart Failure</u>		<u>4 years</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertension</u>		<u>5 years</u>	
(c)			

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION: <u>Sept. 25, 1955</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>April 14, 1951</u> , to <u>Sept. 25, 1955</u> , that I last saw the deceased alive on <u>Sept. 25, 1955</u> , and that death occurred at <u>9:21 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>R.M. McLaughlin, M.D.</u>		DATE SIGNED <u>Sept. 25, 1955</u>	
ADDRESS <u>Pasadena, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		LOCATION (City, town, or county) (State) <u>Green Haven, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singletary</u>		ADDRESS <u>Green Haven, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 3 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8320

## CERTIFICATE OF DEATH

08310

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>				
COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Severn Heights MD</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Severn Ave - Severn Heights MD</u>				STATE <u>MD.</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn Heights, M.D.</u> TOWN <u>SEVERNA PARK, MD</u> STREET ADDRESS <u>Severn Ave.</u>				
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MRS Emma MAe. Baker.</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept 25 1955</u>				
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 3, 1873.</u>		<b>9. AGE last birthday</b> <u>82 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Illinois.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>		
<b>13. FATHER'S NAME</b> <u>Joseph. Milner</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZa Gurlcy.</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Daughter, Severn Heights Md</u> <u>MRS F. HAYES.</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
156.1 IMMEDIATE CAUSE (A) <u>① Cachexia.</u>						<u>6 mo.</u>		
ANTECEDENT CAUSE(S) DUE TO (B) <u>② Generalized Carcinoma</u>								
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>③ Ca. of Liver</u>								
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>								
<b>19a. DATE OF OPERATION</b> <u>—</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>—</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)				
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>				
<b>22. I hereby certify</b> that I attended the deceased from <u>Aug.</u> , 19 <u>54</u> , to <u>Sept 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>25 Sept</u> , 19 <u>55</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.								
<b>SIGNATURE</b> <u>R. Hahn.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Severna Park Md</u>		<b>DATE SIGNED</b> <u>25 Sept 55</u>		
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Jan 29 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>REST HAVEN</u>		<b>LOCATION</b> (City, town, or county) (State) <u>HOUSTON TEXAS</u>		
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>L. J. DeAlba</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Doughton</u>		<b>ADDRESS</b> <u>Glen Burnie, Md</u>		
<b>DATE</b> <u>Sept 27 1955</u>								





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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08311

8321

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Arnold - Arnold</i>	<i>Tyngan</i>	TOWN <i>Arnold, Md.</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<i>1</i>
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<i>VIRGINIUS H. BANKS SR.</i>		<i>SEPT 5 1955</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>11/15/1907</i>
9. AGE last birthday <i>48</i> yrs.		IF UNDER 1 YEAR (Month) (Day) (Year)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESTAURANTEUR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DRIVE-IN</i>	
11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>GEORGE W. BANKS</i>		14. MOTHER'S MAIDEN NAME <i>CORA LEE STRINGER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>V. H. Banks Jr. 2335 N. H. Arlington Va.</i>			
<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<i>12 HRS.</i>	
<i>420.1</i> IMMEDIATE CAUSE (A) <i>ACUTE MYOCARDIAL INFARCTION</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from <i>SEPT 5, 1955</i>, to <i>SEPT 5, 1955</i>, that I last saw the deceased alive on <i>SEPT 5, 1955</i>, and that death occurred at <i>11:57</i> M., from the causes and on the date stated above.</b>			
SIGNATURE <i>J. R. Hederman</i>		DATE SIGNED <i>90 Cathedral St. Annapolis, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>John M. Tyng + Sons ANNAPOLIS MD.</i>	
DATE <i>Sept. 8, 1955</i>		25. FUNERAL DIRECTOR'S SIGNATURE	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08312  
No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Same</b>		COUNTY <b>Same</b> <i>A.A.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> TOWN <b>Ferndale</b>		LENGTH OF STAY (in this place) <b>1 year</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Same</b> <span style="float: right;"><b>X</b></span>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Old Annapolis Rd.</b>				STREET ADDRESS (If rural, give location) <b>6 Clifton Ave.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <b>Vincent Belizzi</b>				4. DATE OF DEATH: (Month) (Day) (Year) <b>Sept. 6 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>4/15/86</b>	9. AGE last birthday: <b>69</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Retired mail carrier.</b>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Italy, Europe.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>David Belizzi</b>				14. MOTHER'S MAIDEN NAME: <b>?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No.: <b>066-05-9861</b>		17. INFORMANT & ADDRESS: <b>Mrs. Susan Belizzi (wife).</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<div style="display: flex; justify-content: space-between;"> <div> <p><b>812X</b></p> <p>Immediate cause (a) <b>Fracture of skull</b></p> <p>DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p> </div> <div> <p><b>Sudden</b></p> </div> </div>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <b>Old Annapolis Rd.</b>		21c. (City or town) (County) (State) <b>Ferndale A.A. Maryland.</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>9/6/55 5.51 P.M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Was hit by an automobile.</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Kristine K. Paubert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/7/55</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.					
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>Sept 7-55</b>		NAME OF CEMETERY OR CREMATORY <b>St Raymond Cemetery</b>		LOCATION (City, town, or county) (State) <b>Beaufort N.Y.</b>	
DATE REC'D BY LOCAL REG <b>September 7, 1955</b>		REGISTRAR'S SIGNATURE <i>L. J. Dalbo</i>		24. FUNERAL DIRECTOR <b>Bernard G. Fink</b>		ADDRESS <b>Baltimore, Md.</b>	

BUREAU V. S.

SEP 9 1955

RECEIVED

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08313

8300

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>Annapolis</u>				10 TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AA General Hospt.</u>				STREET ADDRESS (If rural give location) <u>106 West Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Mary</u> (Middle) <u>Margaret</u> (Last) <u>Blades</u>				(Month) <u>Sept.</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-30-1916</u>	9. AGE last birthday <u>38</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles M. Mullikin</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hope Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Hope Mullikin-Neau H. Md</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
171X IMMEDIATE CAUSE (A) <u>perfrigus infection</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>wound infection (total hysterectomy), carcinoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>in situ of cervix with biopsy and cauterization</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>carcinoma in situ of cervix</u>							
19a. DATE OF OPERATION <u>9/3/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>carcinoma in situ, pelvic adhesions</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/27/55</u> , 19 <u>55</u> , to <u>9/6/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/6/55</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Bozeman</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>9/7/55</u> (State) <u>Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bozman Cemetery</u>		LOCATION (City, town, or county) <u>Bozman Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. J. Connel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hamilton</u>		ADDRESS <u>St. Michael's</u>	
DATE <u>Sept. 8, 1955</u>							

DEATH CERTIFICATE

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. DATE OF DEATH  
9. PLACE OF DEATH  
10. CAUSE OF DEATH  
11. SIGNATURE OF DECEASED  
12. SIGNATURE OF WITNESSES  
13. SIGNATURE OF REGISTRAR  
14. SIGNATURE OF MEDICAL OFFICER  
15. SIGNATURE OF CLERK

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

08213

Reg. Dist. No.

1. NAME AND RESIDENCE OF DECEASED

MARYLAND

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. DATE OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF MEDICAL OFFICER

15. SIGNATURE OF CLERK

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF MEDICAL OFFICER

20. SIGNATURE OF CLERK

BUREAU V. S.

SEP 18 1965

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08314

8323

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>2 days</u>		TOWN <u>Severn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 Third Ave., S.W.</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>George</u> (Middle) <u>E.</u> (Last) <u>Boyer</u>				<u>Sept. 12, 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>white</u>	<u>Widowed</u>	<u>June 3, 1878</u>	<u>78</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Laborer (ret.)</u>		<u>Natl. Plastic Corp.</u>		<u>Anne Arundel Co., Md</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>George W. Boyer</u>				<u>Charlotte T. Friedheffer</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>				<u>Mrs. Clara Reynolds</u> <u>401 Third Ave., S.W.</u> <u>Glen Burnie, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>450.0</u>				<b>IMMEDIATE CAUSE (A)</b> <u>Cardiac Decompression</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>(B)</b> <u>Arteriosclerosis general</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>(C)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan. 1950, to 9/12, 1955, that I last saw the deceased alive on 9/6, 1955, and that death occurred at 2 A.M. from the causes end on the date stated above.</b>							
<b>SIGNATURE</b> <u>B. L. Jones</u>				<b>DATE SIGNED</b> <u>9/13/55</u>			
				<b>ADDRESS</b> (Street, city, town, state)			
				<u>Glen Burnie Md</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<u>Burial</u>		<u>Sept. 15/55</u>		<u>Boyer family cemo</u>		<u>Severn, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Sept 16, 1955</u>		<u>L. J. Deane</u>		<u>T. S. Slaughter</u>		<u>Glen Burnie, Md</u>	

18814

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

18814

REG. DIST. NO.

1. HUSBAND, WIFE, CHILD OR SISTER

2. PLACE OF DEATH

3. NAME

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE

9. TIME

10. PLACE

11. CITY

12. STATE

13. COUNTY

14. ZIP

15. MARRIED

16. SINGLE

17. DIVORCED

18. WIDOW

19. NEVER MARRIED

19. DATE

20. TIME

21. PLACE

22. CITY

23. STATE

24. COUNTY

25. ZIP

26. MARRIED

27. SINGLE

28. DIVORCED

29. WIDOW

30. NEVER MARRIED

31. DATE

32. TIME

33. PLACE

34. CITY

35. STATE

36. COUNTY

37. ZIP

38. MARRIED

39. SINGLE

40. DIVORCED

41. WIDOW

42. NEVER MARRIED

43. DATE

44. TIME

45. PLACE

46. CITY

47. STATE

48. COUNTY

49. ZIP

50. MARRIED

51. SINGLE

52. DIVORCED

53. WIDOW

54. NEVER MARRIED

55. DATE

56. TIME

57. PLACE

58. CITY

59. STATE

60. COUNTY

61. ZIP

62. MARRIED

63. SINGLE

64. DIVORCED

65. WIDOW

66. NEVER MARRIED

67. DATE

68. TIME

69. PLACE

69. CITY

71. STATE

72. COUNTY

73. ZIP

74. MARRIED

75. SINGLE

76. DIVORCED

77. WIDOW

78. NEVER MARRIED

79. DATE

80. TIME

81. PLACE

82. CITY

83. STATE

84. COUNTY

85. ZIP

86. MARRIED

BUREAU V. 8

SEP 19 1955

RECEIVED

INSTRUCTIONS  
1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased.  
2. It should be filled out as soon as possible after death.  
3. It should be filled out in ink.  
4. It should be filled out in the presence of the deceased's family or friends.  
5. It should be filled out in the presence of the deceased's physician or other qualified person.  
6. It should be filled out in the presence of the deceased's family or friends and the physician or other qualified person.  
7. It should be filled out in the presence of the deceased's family or friends and the physician or other qualified person.  
8. It should be filled out in the presence of the deceased's family or friends and the physician or other qualified person.  
9. It should be filled out in the presence of the deceased's family or friends and the physician or other qualified person.  
10. It should be filled out in the presence of the deceased's family or friends and the physician or other qualified person.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8391

## CERTIFICATE OF DEATH

08315

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>10 Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Anne Arundel County Hos.</u>				STREET ADDRESS (If rural give location) <u>Briar Cliff on the Severn</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Katheryn D. Brennan</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept 15 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 19 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Edward J. Brennan Briar Cliff on the Severn</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>				the Severn		3 1/2 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Fracture, supracondylar, rt. femur</u>						3 1/2 hrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		M.					
<b>22. I hereby certify that I attended the deceased from</b> <u>9/11/55</u> , <b>1955</b> , to <u>9/15/55</u> , <b>1955</b> , <b>that I last saw the deceased alive on</b> <u>9/11/55</u> , <b>1955</b> , <b>and that death occurred at</b> <u>12:58 P.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Frank M. Shaffer</u> <b>M.D.</b> <u>Annapolis, Md</u> <b>DATE SIGNED</b> <u>9/15/55</u> <b>ADDRESS</b> (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 19 1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		F.S. FUNERAL DIRECTOR'S SIGNATURE <u>Nancy H. Hunsicker</u>		ADDRESS <u>4204 Ridgewood Ave</u>	

66312

# CERTIFICATE OF DEATH

2831

1. DECEASED PERSON'S NAME OR ALIAS

2. PLACE OF DEATH

3. SEX

4. DATE OF BIRTH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF BURIAL

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF CLERK

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

31. SIGNATURE OF JUDGE

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF CORONER

34. SIGNATURE OF JURY

35. SIGNATURE OF JUDGE

36. SIGNATURE OF CLERK

37. SIGNATURE OF JUDGE

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF CORONER

40. SIGNATURE OF JURY

41. SIGNATURE OF JUDGE

42. SIGNATURE OF CLERK

43. SIGNATURE OF JUDGE

44. SIGNATURE OF SHERIFF

45. SIGNATURE OF CORONER

46. SIGNATURE OF JURY

47. SIGNATURE OF JUDGE

48. SIGNATURE OF CLERK

49. SIGNATURE OF JUDGE

50. SIGNATURE OF SHERIFF

49. SIGNATURE OF CORONER

50. SIGNATURE OF JURY

51. SIGNATURE OF JUDGE

NOTIFICATION

NOTIFICATION OF DEATH TO BE MADE BY THE CLERK OF THE DISTRICT COURT OF BALTIMORE TO THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING THE DEATH.

BUREAU V. A.

SEP 19 1955

RECEIVED

*Handwritten signature*

08316

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

8324

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>BALTIMORE</u> 3Y01-4	
CITY OR TOWN <u>BURAK-PASADENA, P.O. 5 mos.</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		ADDRESS <u>1448 TOWSON ST.</u> Juc	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANTHONY</u> (Middle) <u>ANDREW</u> (Last) <u>BURACZYNSKI</u>				(Month) <u>Sept</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 25, 1892</u>	9. AGE last birthday <u>63</u> yrs.	10. UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julian Buraczynski</u>				14. MOTHER'S MAIDEN NAME <u>EVE Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-05-1964</u>		17. INFORMANT & ADDRESS <u>Cecelia BERTHA - North Shore Pasadena, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Generalized Arteriosclerosis</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Cerebro-vascular Accident</u>				<u>18 hrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Nephrolithiasis, Bilateral</u>				<u>10 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/1</u> , 19 <u>53</u> , to <u>9/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/3</u> , 19 <u>55</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. W. Richard</u>				ADDRESS (Street, city, town, state) <u>715 Colter Rd. Glen Burnie Md</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 9 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Alex. Hauser Cem. Brooklyn Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Sept. 6, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlto</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Hill</u>		ADDRESS <u>1501 E. Fort Ave.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1953

Page One of Two

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY OFFICIAL

20. SIGNATURE OF OTHER

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BUREAU V. B.

SEP 7 1953

KLONOWICZ

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8325 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08317  
Reg. Dist.

No. 24

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Anne Arundel</u>		MARYLAND	STATE <u>Same</u>		COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN <u>Garland Park, Linthicum</u></u>		LENGTH OF STAY (in this place) <u>3 months</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Same</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>211 Poplar Ave.</u>			STREET ADDRESS (If rural, give location) <u>Same</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Harold Carpenter</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 19 19 55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8/30/09</u>	9. AGE last birthday: <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Ardell County, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Samuel Carpenter</u>			14. MOTHER'S MAIDEN NAME: <u>Minnie Jacks</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>242-10-9429</u>	17. INFORMANT & ADDRESS: <u>Mrs. Ethel Carpenter (Wife)</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
<u>420.1</u> <u>Coronary Occlusion</u> Immediate cause (a) DUE TO				<u>Sudden.</u>
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE <u>Ernest H. Fawcett</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <u>9/19/55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>9/22/55</u>	NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>	LOCATION (City, town, or county) (State) <u>Statesville, North Carolina</u>	
DATE REC'D BY LOCAL REG. <u>September 21, 1955</u>	REGISTRAR'S SIGNATURE <u>T. J. DeAlba</u>	24. FUNERAL DIRECTOR ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1965

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8302

## CERTIFICATE OF DEATH

08318

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>164 Green St.</i>				STREET ADDRESS (If rural give location) <i>164 Green St.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>John Wesley Carter</i>				<b>4. DATE OF DEATH</b> (Month) <i>Sept.</i> (Day) <i>19</i> (Year) <i>1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 8, 1878</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steam Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Builder</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John W. Carter</i>				14. MOTHER'S MAIDEN NAME <i>Annie Allen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS <i>Emma L. Carter Same as #2</i>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.0 IMMEDIATE CAUSE (A) CORONARY OCCLUSIVE MYOCARDIAL INFARCT</i>						<i>12 HR</i>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>(B) ARTEROSCLEROTIC HEART DISEASE</i>						<i>UNKNOWN</i>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>JAN</i> , 1955, to <i>SEP</i> , 1955, that I last saw the deceased alive on <i>15 AUG</i> , 1955, and that death occurred at <i>12:30 P.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>Edward A. Beck</i>		M.D. <i>41 Southgate Ave Annapolis Md.</i>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-22-55</i>		NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		LOCATION (City, town or county) (State) <i>Annapolis, Md.</i>	
24. REC'D BY REGISTRAR <i>John M. Taylor</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Same as #2</i>	
DATE <i>Sept. 21, 1955</i>							



1

## INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08319

8326

## CERTIFICATE OF DEATH

Reg. Dist. No.

27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Alabama</u>		COUNTY <u>Limestone</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ft Geo G. Meade, Md.</u>		1 day		TOWN <u>Athens (rural)</u>		40X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u>				STREET ADDRESS (If rural give location)			
50 Rt. 2, Box 220				Rt. 2, Box 220			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
MICHAEL LYNN CHRISTOPHER				September 3, 19 55			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
M		W				September 2, 1955	
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
yrs.		Months Days		Hours Min.		20 30	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
						<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
Lynn Christopher, Jr.				Mattie Faye Chittam			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
No						Lynn Christopher, Jr. (Father) Meade, Cabins, Odenton, Maryland	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>September 2, 55</u> , to <u>September 3, 19 55</u> , that I last saw the deceased alive on <u>September 3, 19 55</u> , and that death occurred at <u>4:00A</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Joseph S. Ardinger</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>2 E. Read St. Balto 2, Md.</u>			
				<b>DATE SIGNED</b> <u>9-3-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
Burial		6 Sept 55		Post Cemetery		Ft. Geo. G. Meade, Maryland	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
DATE <u>9/3/55</u>		<u>W.L. Saylor 1st Lt, MSC</u>					

2095191261

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

1955

Has Out No.

IN REGISTRATION OF DEATHS

STATE OF DEATH

John G. Smith

MARYLAND

John G. Smith

John G. Smith, Jr. 1 day

John G. Smith, Jr.

MARYLAND

John G. Smith

John G. Smith

September 2, 1955

John G. Smith

John G. Smith

John G. Smith, Jr.

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John G. Smith, Jr.

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BUREAU V. 2

SEP 7 1955

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INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

08320  
28

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Crownsville</u>		<u>7 mos. 23 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10 Crownsville State Hospital</u>				<u>1101 Kaiser Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emory</u> (Middle) (Last) <u>Cooper</u>				(Month) (Day) (Year)			
				<u>9 11 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Widowed</u>	<u>Unknown</u>	<u>70?</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Unknown</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Cooper</u>				<u>Emma Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u> (If Yes, give year or dates of service)		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Hypertensive and Arteriosclerotic Cardiovascular Disease</u>						<u>Known to us since 1/19/55</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Generalized and Cerebral arteriosclerosis</u>						<u>" "</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pagets Disease, Polycythemia Vera</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/19/55</u> , 19 <u>55</u> , to <u>9/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/11/</u> , 19 <u>55</u> , and that death occurred at <u>4:15pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stanley Chacean</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>9/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>SEPT 15 1955</u>		<u>VOF M MEDICAL SCHOOL</u>		<u>295 GREEN ST MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Sept. 16, 1955</u>		<u>Eatherine M. Joyce</u>		<u>Duffel Bros</u>		<u>1800 ELOMBARK ST</u>	



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1955

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Place of Birth	
Manner of Death		Physician's Signature		Date of Report	
Registrar's Signature		Date of Registration		Place of Registration	

BUREAU V.

SEP 19 1955

RECEIVED

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This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death. It should be filled out as soon as possible after death and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the Commonwealth of Massachusetts.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08321

8328

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Millersville</u>		<u>39 days</u>		TOWN <u>Lothian</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>Sann's Nursing Home</u>				/			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Blanche L. Cotterton</u>				<u>September 30 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	<u>White</u>	<u>Single</u>	<u>10/23/85</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housekeeper</u>				<u>Anne Arundel County, Md.</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Virgil Cotterton</u>				<u>Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				<u>Sann's Nursing Home Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1450.0 IMMEDIATE CAUSE (A) <u>General Arteriosclerosis</u>						<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>8/24/55</u> , 19....., to <u>9/30/55</u> , 19....., that I last saw the deceased alive on <u>9/26/55</u> , 19....., and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Eustace H. Paubert, M.D.</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>9/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>At 21955</u>		<u>Mt Calvary</u>		<u>Bristol, Ind</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-4-55</u>		<u>1st M Joyce</u>		<u>Bernard Hardisty</u>		<u>Galesville, Ind</u>	

BUREAU V. S.

OCT 2 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third, copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08322

8303

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u> <b>MARYLAND</b>		STATE <u>MD</u> COUNTY <u>AA. Co. MDX</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>1 DAY</u>		TOWN <u>ROUTE-2 B495 D. ANNAPOLIS</u>		TOWN <u>ROUTE-2 B495 D. ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GENERAL</u>		STREET ADDRESS (If rural give location) <u>RIVER BAY-ROAD</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MARY MARGARET CSCHENK</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>SEPT 19 1955</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWER, DIVORCED</b> (Specify) <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>Dec 12 - 1911</u>	<b>9. AGE last birthday</b> <u>43</u> yrs.	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
		Months	Days	Hours	Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Davidson Chemical</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balt Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Henry Cschenk</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary M. Bartels</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-20-5475</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mary M. Cschenk - c.o. Co. 2nd</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>170X IMMEDIATE CAUSE (A)</b> <u>Broncho-pneumonia</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 hrs</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Carcinoma of Left Breast</u>				<u>1 mo</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Carcinoma of Left Breast</u>				<u>6 mo</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>2</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>French</u> <u>1955 9-19</u> <u>35</u> <b>to</b> <u>19 35</u> <b>that I last saw the deceased alive on</b> <u>9/19/55</u> <b>and that death occurred at</b> <u>11 PM</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James D. French</u>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state) <u>Annapolis Md</u>		<b>DATE SIGNED</b> <u>9/19/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Sept 22/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Landon Park</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Balt Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Sept. 21, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Wm. J. French</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John T. Geipel</u>		<b>ADDRESS</b> <u>5311 Edmondson Ave</u>	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08323

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Anne Arundel</b>		STATE <b>MARYLAND</b>		STATE <b>Ohio</b>		COUNTY <b>Lucas</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Fort George G. Meade</b>		<b>2 days</b>		TOWN <b>Toledo</b>		<b>72 X -3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U. S. Army Hospital</b>				STREET ADDRESS (If rural give location) <b>3739 Upton Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>THOMAS MICHAEL CURRAN</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>September 6 19 55</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>		<b>8. DATE OF BIRTH</b> <b>September 4, 1955</b>	
<b>9. AGE last birthday</b> <b>37</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Robert Joseph Curran</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Betty Jane Delo</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Father, 3739 Upton Avenue, Toledo 13, Ohio</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE</b> (A) <b>Prematurity</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>37 hrs.</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B)							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>None</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>None</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <b>M.</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>4 September 1955</b> to <b>6 September 1955</b> , that I last saw the deceased alive on <b>6 September 1955</b> , and that death occurred at <b>1:15 AM</b> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>MURRAY K. MANTOOTH, MD</b>				<b>DATE SIGNED</b> <b>6 Sept 55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>7 September 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Post Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Fort G.G. Meade, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>6 September 55</b>		<b>WILLIAM L. SAYLOR, 1ST LT MSC</b>					

2095221291



# CERTIFICATE OF DEATH

3358

1. NAME OF DECEASED: **JOHN J. HARRIS**

2. SEX: **MALE**

3. AGE: **65**

4. DATE OF BIRTH: **1870**

5. PLACE OF BIRTH: **NEW YORK**

6. OCCUPATION: **LABORER**

7. CAUSE OF DEATH: **HEART DISEASE**

8. DATE OF DEATH: **1935**

9. PLACE OF DEATH: **HOME**

10. SIGNATURE OF DECEASED: **[Signature]**

11. SIGNATURE OF WITNESSES: **[Signatures]**

12. SIGNATURE OF PHYSICIAN: **[Signature]**

13. SIGNATURE OF REGISTRAR: **[Signature]**

14. SIGNATURE OF CLERK: **[Signature]**

15. SIGNATURE OF JUDGE: **[Signature]**

16. SIGNATURE OF SHERIFF: **[Signature]**

17. SIGNATURE OF CORONER: **[Signature]**

18. SIGNATURE OF JURY: **[Signatures]**

19. SIGNATURE OF COURT: **[Signature]**

20. SIGNATURE OF JUDGE: **[Signature]**

21. SIGNATURE OF SHERIFF: **[Signature]**

22. SIGNATURE OF CORONER: **[Signature]**

23. SIGNATURE OF JURY: **[Signatures]**

24. SIGNATURE OF COURT: **[Signature]**

25. SIGNATURE OF JUDGE: **[Signature]**

26. SIGNATURE OF SHERIFF: **[Signature]**

27. SIGNATURE OF CORONER: **[Signature]**

28. SIGNATURE OF JURY: **[Signatures]**

29. SIGNATURE OF COURT: **[Signature]**

BUREAU V. 2

SEP 8 1935

RECEIVED

FOR C.D. RECORD

SEP 10 1935



# MARYLAND STATE DEPARTMENT OF HEALTH

8330

2411 N. Charles Street, Baltimore

08324

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

Items 8, 9, Film G189 11-16-55 et

1. PLACE OF DEATH- COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BRISTOL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u>	
TOWN <u>BRISTOL</u> LENGTH OF STAY (in this place) <u>Life</u>		TOWN <u>SEAT PLEASANT</u> 02X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>6625 Central Ave - 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>LAURA</u> (Middle) <u>Indiana</u> (Last) <u>CURRLEY</u>		4. DATE OF DEATH (Month) <u>9</u> (Day) <u>30</u> (Year) <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 20 1889</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George W Carr</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Wood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Bernice B Gibson</u>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
260X Immediate cause	(a) <u>Cerebral Vascular Accident</u>	<u>24 hrs</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerosis</u>	<u>unk</u>
	(c) <u>Diabetes Mellitus</u>	<u>unk</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 29 Sept, 1955, to 30 Sept, 1955, that I last saw the deceased alive on 29 Sept, 1955, and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE J. J. Jasser (Degree or title) MD ADDRESS Upper Marlboro, Md DATE SIGNED 30 Sept 53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>10/3/55</u>	<u>Cedar Hill</u>	<u>Seat Pleasant Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Oct. 1-55</u>	<u>Carrie Campbell</u>	<u>W. W. Chambers &amp; Co</u>	<u>517-11 St. E Wash D C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 5 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08325

8331

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>		LENGTH OF STAY (in this place) <u>21 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		<u>X</u>	
TOWN <u>RIVA</u>				STREET ADDRESS (If rural give location) <u>Arden on the Severn</u>		<u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RIVERVIEW NURSING HOME</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>BESSIE LOUISA DAY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>SEPT 21 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MARCH 19, 1878</u>	
				9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE (RETD)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	
13. FATHER'S NAME <u>NELSON THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE STOLTB.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>RUFUS DAY CROWNSVILLE, MD.</u>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Congestive failure</u>				<u>2 wks.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5</u> <u>1955</u> <u>9/21/55</u> , to <u>9/22/55</u> , that I last saw the deceased alive on <u>9/20/55</u> , 19 <u>55</u> , and that death occurred at <u>1:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shuply</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md.</u>			
DATE <u>Sept 24, 1955</u>				DATE SIGNED <u>9/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept-23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Hallinan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>RV Singler</u>		ADDRESS <u>Sh. Burns, Md.</u>	



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## INSTRUCTIONS

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VS AISC 1-55 10M

8333

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08328

## CERTIFICATE OF DEATH

Item 9, Film G187 10-11-55 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>	
TOWN <i>Ann</i>		LENGTH OF STAY (in this place) <i>2 yrs 9 mos</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		TOWN <i>3V01-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Crownsville State Hosp.</i>				STREET ADDRESS (If rural give location) <i>1313 Stockton St</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Sarah Elizabeth Evans</i>				<b>4. DATE OF DEATH</b> (Month) <i>9</i> (Day) <i>25</i> (Year) <i>1955</i>			
<b>5. SEX</b> <i>Female</i>		<b>6. COLOR OR RACE</b> <i>Negro</i>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Single</i>		<b>8. DATE OF BIRTH</b> <i>5/25/85</i>	
<b>9. AGE last birthday</b> <i>16</i> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <i>Joseph Evans</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Margaret Howard</i>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>	
<b>16. SOCIAL SECURITY NO.</b> <i>unknown</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Daniel Evans 8351 South Markoe St Phila, Pa.</i>		<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <i>Cerebrovascular Accident</i>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Essential Hypertension</i>				<b>21. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>19a. DATE OF OPERATION</b> <i>None</i>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>			
<b>21e. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>				<b>21f. HOW DID INJURY OCCUR?</b>			
<b>21g. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/></b>				<b>22. I hereby certify that I attended the deceased from <i>9/24</i>, 19<i>55</i>, to <i>9/25</i>, 19<i>55</i>, that I last saw the deceased alive on <i>9/25</i>, 19<i>55</i>, and that death occurred at <i>8:00</i> A.M., from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS (Street, city, town, state)</b>			
<b>DATE SIGNED</b>				<b>DATE SIGNED</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>BURIAL</i>		<b>DATE THEREOF</b> <i>9-29-55</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>PLEASANT REST CEM.</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Towson Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b>	
<b>DATE</b> <i>9-29-55</i>							





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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08329

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

8324

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10</u>				TOWN <u>Annapolis, Md.</u> <u>10</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>57 U.S. Naval Hospital, Annapolis, Md</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Baby Boy</u> <u>FOGLIA</u>				<u>September 4</u> <u>19</u> <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>4 September 1955</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Carl Robert FOGLIA</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Catherine Hayden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>U.S. Naval Hospital Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
776X IMMEDIATE CAUSE (A) <u>Prematurity with Immaturity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-4-55</u> , 19 <u>55</u> , to <u>9-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-4</u> , 19 <u>55</u> , and that death occurred at <u>1100 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Carl Peters</u>				ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>			
C.R. PETERS LTMC USN				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Naval Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>9-6-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1955

12

NAME OF DECEASED

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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BUREAU V. S.

SEP 7 1955

RECEIVED

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## INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08330

8305

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Mo.</u>		COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD</u>		TOWN <u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A.A. GENERAL Hospt.</u>				STREET ADDRESS (If rural give location) <u>123 CHESAPEAKE AV.</u>			
3. NAME OF DECEASED (Type or Print) <u>SAMUEL E. FREEMAN</u>				4. DATE OF DEATH <u>9 29 19 55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>7/6/1888</u>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10f. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		9. AGE last birthday <u>67</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. FREEMAN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH R. JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>SAMUEL E. FREEMAN JR #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						6-8 mos.	
157X IMMEDIATE CAUSE (A) <u>CARCINOMA HEAD PANCREAS</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 SEPT, 19 55</u> , to <u>29 SEPT, 19 55</u> , that I last saw the deceased alive on <u>29 SEPT, 19 55</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward H. Beck</u>		M.D. <u>41 Southgate ANNAPOLIS</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>10/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>	
24. REC'D BY REGISTRAR <u>Oct. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

RECEIVED

OCT 12 1955

BUREAU V. 2

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF OFFICIAL	
13. SIGNATURE OF OFFICIAL		14. SIGNATURE OF OFFICIAL		15. SIGNATURE OF OFFICIAL	
16. SIGNATURE OF OFFICIAL		17. SIGNATURE OF OFFICIAL		18. SIGNATURE OF OFFICIAL	
19. SIGNATURE OF OFFICIAL		20. SIGNATURE OF OFFICIAL		21. SIGNATURE OF OFFICIAL	
22. SIGNATURE OF OFFICIAL		23. SIGNATURE OF OFFICIAL		24. SIGNATURE OF OFFICIAL	
25. SIGNATURE OF OFFICIAL		26. SIGNATURE OF OFFICIAL		27. SIGNATURE OF OFFICIAL	
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61. SIGNATURE OF OFFICIAL		62. SIGNATURE OF OFFICIAL		63. SIGNATURE OF OFFICIAL	
64. SIGNATURE OF OFFICIAL		65. SIGNATURE OF OFFICIAL		66. SIGNATURE OF OFFICIAL	
67. SIGNATURE OF OFFICIAL		68. SIGNATURE OF OFFICIAL		69. SIGNATURE OF OFFICIAL	
70. SIGNATURE OF OFFICIAL		71. SIGNATURE OF OFFICIAL		72. SIGNATURE OF OFFICIAL	
73. SIGNATURE OF OFFICIAL		74. SIGNATURE OF OFFICIAL		75. SIGNATURE OF OFFICIAL	
76. SIGNATURE OF OFFICIAL		77. SIGNATURE OF OFFICIAL		78. SIGNATURE OF OFFICIAL	
79. SIGNATURE OF OFFICIAL		80. SIGNATURE OF OFFICIAL		81. SIGNATURE OF OFFICIAL	
82. SIGNATURE OF OFFICIAL		83. SIGNATURE OF OFFICIAL		84. SIGNATURE OF OFFICIAL	
85. SIGNATURE OF OFFICIAL		86. SIGNATURE OF OFFICIAL		87. SIGNATURE OF OFFICIAL	
88. SIGNATURE OF OFFICIAL		89. SIGNATURE OF OFFICIAL		90. SIGNATURE OF OFFICIAL	
91. SIGNATURE OF OFFICIAL		92. SIGNATURE OF OFFICIAL		93. SIGNATURE OF OFFICIAL	
94. SIGNATURE OF OFFICIAL		95. SIGNATURE OF OFFICIAL		96. SIGNATURE OF OFFICIAL	
97. SIGNATURE OF OFFICIAL		98. SIGNATURE OF OFFICIAL		99. SIGNATURE OF OFFICIAL	
100. SIGNATURE OF OFFICIAL		101. SIGNATURE OF OFFICIAL		102. SIGNATURE OF OFFICIAL	

CERTIFICATE OF DEATH

28-12

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10-380

NOTIFICATION

THE SIGNATURE OF THE DECEASED OR HIS NEAREST RELATIVE OR A PERSON HAVING KNOWLEDGE OF THE DECEASED'S WHEREABOUTS MUST BE OBTAINED AND THE DECEASED'S NAME AND ADDRESS MUST BE FURNISHED TO THE NEAREST RELATIVE OR A PERSON HAVING KNOWLEDGE OF THE DECEASED'S WHEREABOUTS. THE DECEASED'S NAME AND ADDRESS MUST BE FURNISHED TO THE NEAREST RELATIVE OR A PERSON HAVING KNOWLEDGE OF THE DECEASED'S WHEREABOUTS. THE DECEASED'S NAME AND ADDRESS MUST BE FURNISHED TO THE NEAREST RELATIVE OR A PERSON HAVING KNOWLEDGE OF THE DECEASED'S WHEREABOUTS.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08331

8334

## CERTIFICATE OF DEATH

Items 7,9, Film GL89 11-16-55 et

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u> COUNTY <u>A.A.</u>		CITY <u>Severna Park</u>		CITY <u>Severna Park</u>	
CITY OR TOWN <u>Severna Park</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Severna Park</u>		CITY OR TOWN <u>Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR (C.N.V. HOME)</u>		STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>ALFRED</u>		(Middle) <u>GILLIS</u>		(Last) <u>GILLIS</u>		(Date) <u>9</u> (Month) <u>8</u> (Year) <u>1955</u>	
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>		<b>8. DATE OF BIRTH</b> <u>12-6-1892</u>	
<b>9. AGE last birthday</b> <u>62</u> yrs.		<b>10. IF UNDER 1 YEAR</b> <u>8</u> Months <u>8</u> Days		<b>11. IF UNDER 24 HRS.</b> <u>8</u> Hours <u>55</u> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Gardener</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Florist</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <u>Newton Gillis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Susan Gillis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT &amp; ADDRESS</b> <u>Bertha Louise Gillis Anna, Md.</u>							
<b>18. MEDICAL CERTIFICATION</b>				<b>19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Cerebral occlusion</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arterio-sclerotic heart disease</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Congestive heart failure</u>							
<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>			
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)				<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute)			
<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify, that I attended the deceased from</b> <u>Aug 7, 1955</u> <b>to</b> <u>Sept 8, 1955</u> <b>that I last saw the deceased alive on</b> <u>Sept 1, 1955</u> <b>and that death occurred at</b> <u>4:30 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Joseph H. Tate</u>				<b>DATE SIGNED</b> <u>9/8/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>24. DATE THEREOF</b> <u>9-12-55</u>			
<b>25. NAME OF CEMETERY OR CREMATORY</b> <u>Baptist</u>				<b>26. LOCATION (City, town, or county)</b> <u>Garleigh Heights, Md.</u>			
<b>27. REC'D BY REGISTRAR</b> <u>L. J. O'Neil</u>				<b>28. REGISTRAR'S SIGNATURE</b> <u>William Rose, Jr.</u>			
<b>29. DATE</b> <u>Sept. 9, 1955</u>				<b>30. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Rose, Jr.</u>			
<b>31. ADDRESS</b> <u>1085 Ash. St. Annapolis, Md.</u>							



## 5902

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The General

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Travel

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William Westcott

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Willie

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Bartholomew's Island

BUREAU V. S.

SEP 13 1955

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General P-15-225-10-10

42. *Arctostaphylos* - *Arctostaphylos* - *Arctostaphylos*



8335

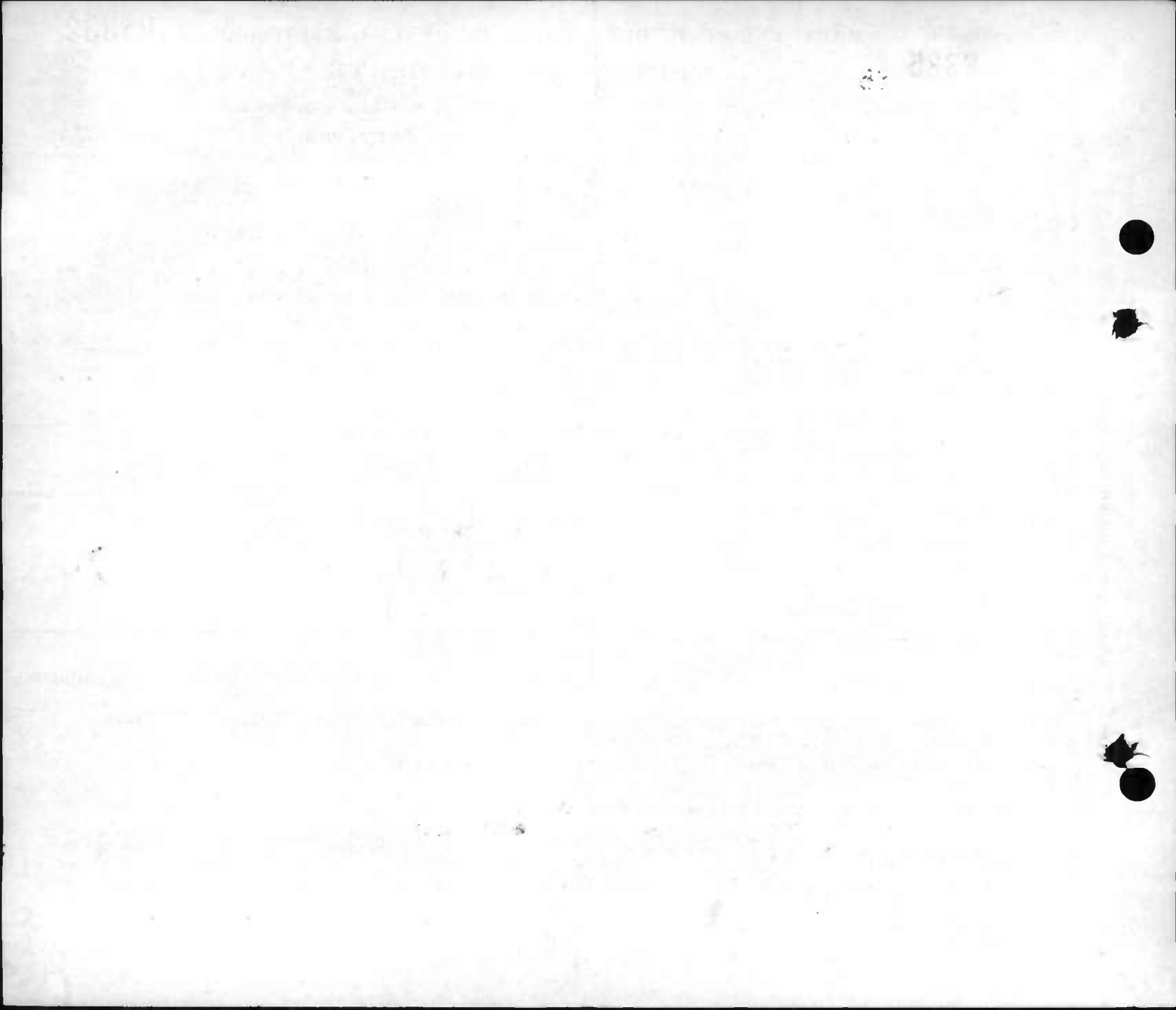
## CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY A.A.		MARYLAND		STATE Maryland		COUNTY A.A.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Rural-Brooklyn Park				TOWN Rural-Brooklyn Park		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4203 Ritchie Hwy.				STREET ADDRESS (If rural give location) 4203 Ritchie Hwy.			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)					
Lillie Brinkman Gray		Sept. 6, 1955					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: If UNDER 1 YEAR	10. IF UNDER 24 HRS.		
F.	W.	Widowed	Oct. 11, 1870	84 yrs.	Months Days Hours Min:		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Homemaking		Maryland		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Henry Brinkman				Laura Stoll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		W. Calvin Gray 4203 Ritchie Hwy.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
331X Immediate cause (a) DUE TO Cerebral Hemorrhage						1 hr	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Arterial Hypertension						8 yrs	
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At Work		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from 1950, to Sept 1955, that I last saw the deceased alive on Sept 6, 1955, and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
P. J. Gmmls, M.D.				4609 G.W. Ritchie Hwy. 9-8-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Buried		9/9/55		Cedar Hill		A.A. Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept 9/55		H. H. Hedrick		George J. Gance		4001 Ritchie Hwy	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**INSTRUCTIONS**  
**1**  
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 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 115C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8336

# CERTIFICATE OF DEATH

08334

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u> <b>MARYLAND</b>		STATE <u>Md.</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL OR TOWN) <u>PASADENA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>PASADENA</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>RFD 1, Box 211</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>				STREET ADDRESS <u>RFD 1, Box 211</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHLEO</u> (First) <u>VERNA</u> (Middle) <u>GRIFFITH</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>9</u> (Day) <u>1</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>married</u>	<b>8. DATE OF BIRTH</b> <u>4/1/1899</u>		<b>9. AGE last birthday</b> <u>56</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Penna.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>John Marsh</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Harbaugh</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr. Philip G. Griffith-RFD #1; Pasadena Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>153X</b> IMMEDIATE CAUSE (A) <u>Carcinomatosis general</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of large intestine</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>intestine</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>  </u> M. <u>  </u> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>6/30/54</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Joseph Taler</u> M.D. <u>102 Balto. - Penna. Blvd. N. E. Corner Baltimore, Md.</u>				<b>DATE SIGNED</b> <u>9/1/1955</u> (State)			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>9/3/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Moreland Mem. Pr.</u>		<b>LOCATION</b> (City, town, or county) <u>Balto., Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Sept. 2, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Louis J. De Alleg</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Tiekens &amp; Sons - Balto. Md.</u>		<b>ADDRESS</b>	

RECEIVED

SEP 4 1915

BUREAU V. 2

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

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**CERTIFICATE OF DEATH**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

9343

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b> <b>Crownsville</b>		LENGTH OF STAY (In this place) <b>39 yrs. 11 mos.</b>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		<b>3V01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>10</b> <b>Crownsville State Hospital</b>				STREET ADDRESS (If rural give location) <b>Unknown</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>Adrianna Gwyder</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>9 30 19 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>6/11/68</b>	9. AGE last birthday <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>		IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>— — — —</b>		17. INFORMANT & ADDRESS <b>Hospital Records</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
493X IMMEDIATE CAUSE (A) <b>Pneumonia</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypostasis, malnutrition</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arteriosclerotic heart disease</b>							
19a. DATE OF OPERATION <b>— — — —</b>		19b. MAJOR FINDINGS OF OPERATION <b>— — — — — — — — — —</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>— — — — —</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>— — — — —</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <b>— — — — —</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>— — — — —</b>			
22. I hereby certify that I attended the deceased from <b>1/21</b> , 19 <b>48</b> , to <b>9/30</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9/30</b> , 19 <b>55</b> , and that death occurred at <b>6:45am</b> , from the causes and on the date stated above.							
SIGNATURE <b>L. Benedict, M.D.</b>		ADDRESS (Street, city, town, state) <b>Crownsville, Md.</b>		DATE SIGNED <b>9/30/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		DATE THEREOF <b>OCT 3 1955</b>		NAME OF CEMETERY OR CREMATORY <b>U OF M MEDICAL SCHOOL</b>		LOCATION (City, town, or county) (State) <b>GREEN ST MD.</b>	
24. REC'D BY REGISTRAR <b>Oct. 7, 1955</b>		REGISTRAR'S SIGNATURE <b>Katherine M. Joyce</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Doppel Bros.</b> ADDRESS <b>1800 ELOMBARD ST</b>			





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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

83'6

## CERTIFICATE OF DEATH

08335

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 Annapolis</u>				TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>601 Creek View Ave</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Maudie K. Hackett</u>				<u>9-18-1935</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>7</u>	<u>W</u>	<u>Widow</u>	<u>1-30-1878</u>	<u>77</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>		<u>None</u>		<u>Ohio</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>George H. Keller</u>				<u>Cora Wagner</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>9</u>				<u>A. G. Mason</u> <u>(2)</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>260X IMMEDIATE CAUSE</b> (A)				<u>Cerebral Vascular Accident</u>			
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B)				<u>Arteriosclerosis</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST,</b> DUE TO (C)				<u>Diabetes Mellitus</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY-street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>3/23/1935</u>, to <u>9/18/1935</u>, that I last saw the deceased alive on <u>9/12/1935</u>, and that death occurred at <u>1:27 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Frank M. Shufly</u>				<u>9/18/35</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>				<u>Evergreen Cemetery</u>		<u>Detroit MICH.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Sept. 20, 1935</u>		<u>J. O. Daniel</u>		<u>John M. Taylor &amp; Sons</u>			



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

08336

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ANNE ARUNDEL</i>		MARYLAND		STATE <i>Mo.</i>		COUNTY <i>A.A. Co.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <i>Annapolis</i>				TOWN <i>RURAL Annapolis</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
163 <i>A.A. GENERAL Hospt.</i>				<i>FAIRFAX ROAD</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Julius G. HALL</i>				<i>9 21 19 55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>W</i>	<i>Widow</i>	<i>May 13 1872</i>	<i>83</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>FARMER</i>		<i>TOBACCO</i>		<i>MARYLAND</i>		<i>USA</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William F. HALL</i>				<i>"UNK"</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>g -</i>		<i>-</i>		<i>William Hall # 2</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<i>24 hrs.</i>	
902.0 IMMEDIATE CAUSE (A) <i>Fracture Femur Right - Fracture Elbow Right</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Shock</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>0</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		<i>Home</i>		<i>Home</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>9 21 55 A M.</i>				<i>Fell out of Window, 2nd Story.</i>			
22. I hereby certify that I attended the deceased from <i>9/21/55</i> , 19 <i>55</i> , to <i>9/21</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9/21</i> , 19 <i>55</i> , and that death occurred at <i>1:30 P.</i> M., from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Chambers</i>		<i>Chambers</i>		<i>Annapolis, Md.</i>		<i>9/21/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>9/23/55</i>		<i>Methodist Church Cem.</i>		<i>Prince Frederick, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Sept 23, 1955</i>		<i>J. J. Russell</i>		<i>John M. Lytle, Sr.</i>		<i>Annapolis, Md.</i>	

# CERTIFICATE OF DEATH

NAME OF DECEASED  
JAMES G. JONES  
AGE  
38  
SEX  
M  
DATE OF DEATH  
MAY 12 1955  
PLACE OF DEATH  
MARYLAND

CAUSE OF DEATH  
Typhoid  
MAY 12 1955  
JAMES G. JONES

NAME OF DECEASED  
JAMES G. JONES  
AGE  
38  
SEX  
M  
DATE OF DEATH  
MAY 12 1955  
PLACE OF DEATH  
MARYLAND

CAUSE OF DEATH  
Typhoid  
MAY 12 1955  
JAMES G. JONES

BUREAU V. 4

SEP 28 1955

RECEIVED

NOT RECORDED

8337

08337

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

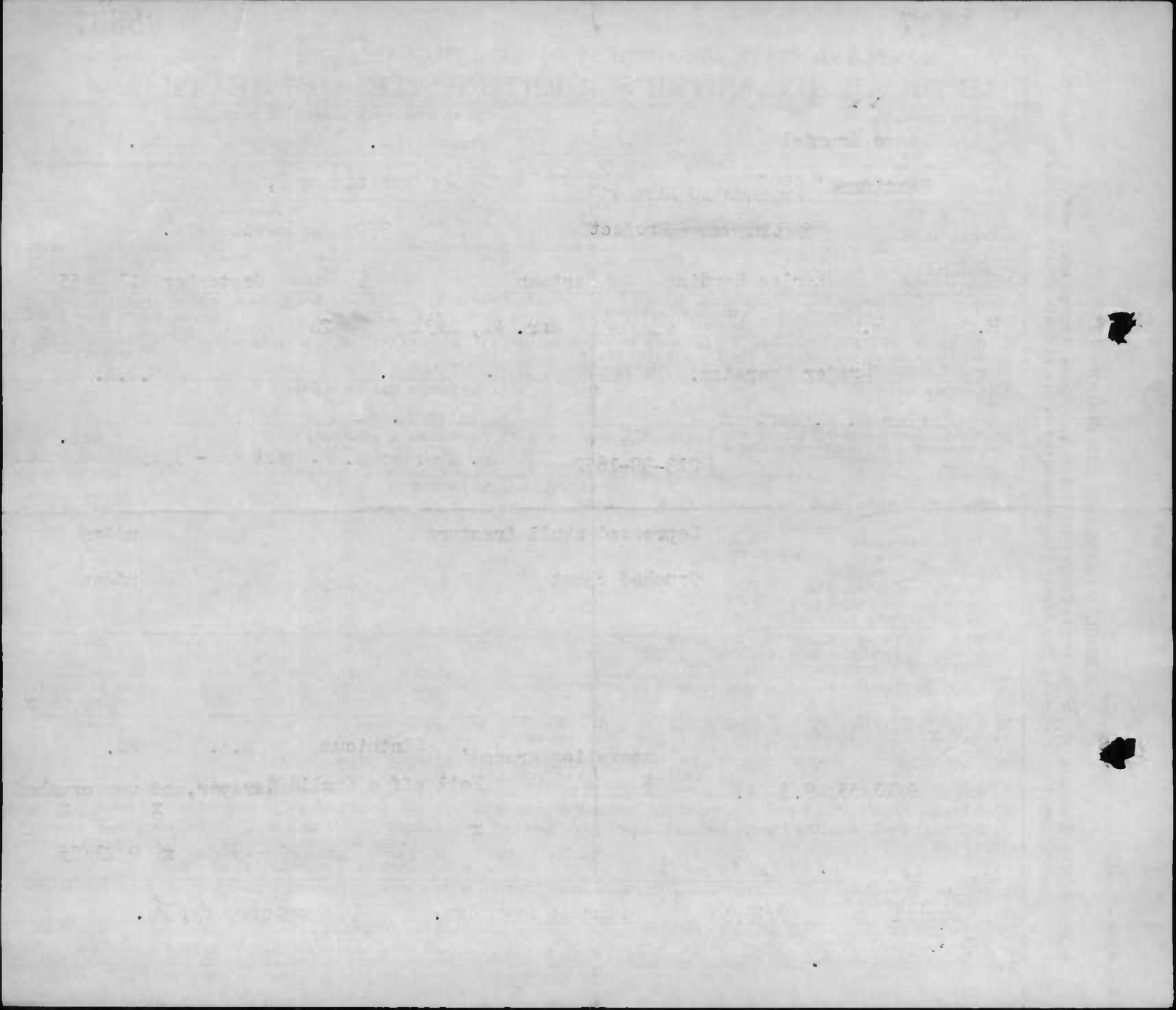
No. 272

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Baltimore</b>	LENGTH OF STAY (in this place) <b>near Friendship Airport</b>	CITY (If outside corporate limits write RURAL and give nearest town) <b>Baltimore 7,</b>	<b>03X-2</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Westinghouse Project</b>		STREET ADDRESS (If rural, give location) <b>3525 Meadowside Ave.</b>	
3. NAME OF DECEASED: (First) <b>Charles Harding</b> (Middle) <b>Hartman</b> (Last)		4. DATE OF DEATH (Month) <b>September</b> (Day) <b>21</b> (Year) <b>1955</b>	
5. SEX: <b>M.</b>	6. COLOR OR RACE: <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>Mar. 21, 1931</b>
9. AGE last birthday: <b>24</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Grader Operator, Excavating Contr.</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Penna.</b>	11. BIRTHPLACE (State or foreign country): <b>U.S.A.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <b>Charles S. F. Hartman</b>	
14. MOTHER'S MAIDEN NAME: <b>Velva K. Kling</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <b>213-30-1652</b>		17. INFORMANT & ADDRESS: <b>Mr. Charles S. F. Hartman - 3525 Meadowside Ave.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <b>Depressed skull fracture</b>		<b>Sudden</b>
DUE TO		
Antecedent cause(s) (b) <b>Crushed chest</b>		<b>Sudden</b>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <b>Excavating ground, Linthicum</b>	(County) <b>A.A.</b> (State) <b>Md.</b>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>9/21/55 9.50 A.M.</b>	21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell off a Euclid Scrapor, and was crushed</b>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <b>Kurt H. P. ...</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>9/21/55</b>
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>9/25/55</b>	NAME OF CEMETERY OR CREMATORY <b>Lincoln Lawn Cem.</b>
LOCATION (City, town, or county) <b>Chambersburg, Pa.</b>		(State)
DATE REC'D BY LOCAL REG. <b>9-23-55</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	24. FUNERAL DIRECTOR <b>Mr. J. T. ...</b>
ADDRESS <b>Balto 17 Md.</b>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8338

## CERTIFICATE OF DEATH

08338

Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>1 yr 6 mo 15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Maryland Penitentiary since</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS <u>June 5, 1953</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Alvon Welch Hayden</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 4 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8/18/16</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Preacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Preaching</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Douglas Hayden</u>				14. MOTHER'S MAIDEN NAME <u>Maude (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Hospital records.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>443X Congestive heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>						Known to us since <u>7/26/54</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work No white <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 19 54</u> , to <u>Sept. 4 19 55</u> , that I last saw the deceased alive on <u>Sept. 4 19 55</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stephen E. Kramer</u>		DATE THEREOF <u>9-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Shadow Lawn</u>		LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REGD BY REGISTRAR <u>Sept. 9, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Latherine M. Joya</u>		ADDRESS <u>108 W. Wash. Street Annapolis, Md.</u>	

CERTIFICATE OF DEATH

Reg. One No.

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH (Print or Write)

7. MANNER OF DEATH (Print or Write)

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEAREST RELATIVE

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH (Print or Write)

7. MANNER OF DEATH (Print or Write)

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEAREST RELATIVE

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

BUREAU V. S.

RECEIVED

SEP 18 1955

Amputation, right

General

1

INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8339

## CERTIFICATE OF DEATH

08339

Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>1yr. 3 mos. 13 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1326 Pennsylvania Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Charles</u>		(Middle) <u>S.</u>		(Last) <u>Hayes</u>		(Month) <u>9</u> (Day) <u>13</u> (Year) <u>19 55</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Divorced</u>	<b>8. DATE OF BIRTH</b> <u>Unknown</u>	<b>9. AGE last birthday</b> <u>48?</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
					Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Spray Painter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unk.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>201X</u> IMMEDIATE CAUSE (A) <u>Medulary paralysis resulting from disseminated</u>							
ANTECEDENT CAUSE(S) DUE TO <u>lesion</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Hodgkins Disease</u>							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>2</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>5/30/54</u> , 19 <u>54</u> , to <u>9/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>55</u> , and that death occurred at <u>5:30 a.m.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>L. Benedict, M. D.</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Crownsville, Md.</u>		<b>DATE SIGNED</b> <u>9/13/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE OF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>9/16/55</u>		<u>Crownsville State Hosp.</u>		<u>Crownsville</u>		<u>Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>19-56-58</u>		<u>L. M. Joyce</u>		<u>Arnold H. Eichert, M.D. Crownsville, Md.</u>			

# CERTIFICATE OF DEATH

9558

9558

1. NAME, RESIDENCE, PLACE OF DEATH

NAME: JAMES H. HARRIS, JR. RESIDENCE: 1000 N. W. 10th Ave. PLACE OF DEATH: 1000 N. W. 10th Ave.

2. SEX AND AGE

SEX: Male AGE: 45

3. OCCUPATION AND CAUSE OF DEATH

OCCUPATION: Teacher CAUSE OF DEATH: Heart Disease

4. DATE OF DEATH

DATE OF DEATH: 10/12/55

5. TIME OF DEATH

TIME OF DEATH: 10:00 AM

6. PLACE OF DEATH

PLACE OF DEATH: 1000 N. W. 10th Ave.

7. SIGNATURE OF DECEASED

SIGNATURE OF DECEASED: JAMES H. HARRIS, JR.

8. SIGNATURE OF WITNESSES

SIGNATURE OF WITNESSES: JAMES H. HARRIS, JR.

9. SIGNATURE OF PHYSICIAN

SIGNATURE OF PHYSICIAN: JAMES H. HARRIS, JR.

10. SIGNATURE OF REGISTRAR

SIGNATURE OF REGISTRAR: JAMES H. HARRIS, JR.

11. SIGNATURE OF CLERK

SIGNATURE OF CLERK: JAMES H. HARRIS, JR.

12. SIGNATURE OF DECEASED

SIGNATURE OF DECEASED: JAMES H. HARRIS, JR.

NOTED/12/11

BUREAU V. 3

SEP 21 1955

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8340

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08340  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 22

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Laurel</u>		<u>25 yrs.</u>		STREET ADDRESS		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>= First made Rd.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Karry Tilden Henderson</u>				<u>9/11/55</u> 19			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>12/8/76</u>	9. AGE last birthday: <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired attendant at State Training School.</u>				11. BIRTHPLACE (State or foreign country): <u>Wheeler County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10b. KIND OF BUSINESS OR INDUSTRY:							
13. FATHER'S NAME: <u>Littleton Henderson</u>				14. MOTHER'S MAIDEN NAME: <u>Marjaret Clegg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Luella Henderson (wife)</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO				<u>Sudden</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Kustase H. Pachter, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/12/55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>9/14/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Garner Memorial Park</u>		LOCATION (City, town, or county) (State): <u>Ministerville, Maryland</u>	
DATE REC'D BY LOCAL REG: <u>Sept 12-55</u>		REGISTRAR'S SIGNATURE: <u>Clara Kaslup</u>		24. FUNERAL DIRECTOR: <u>De Wita-Ronaldson, Laurel, Md.</u>		ADDRESS:	

BUREAU V. 8

SEP 15 1955

RECEIVED



83'8

Item 14. Film 186 9-16-55 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 08341

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

## 1. PLACE OF DEATH:

COUNTY

Annapolis

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN

STREET ADDRESS

(If rural, give location)

## 3. NAME OF DECEASED:

(Type or Print)

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO (c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

September 10, 1955

R.C.M.

Eugene H. Mayo, 609 George St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322 UCBAW/STP

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
BUREAU OF PUBLIC HEALTH  
DIVISION OF FIELD OPERATIONS  
WASHINGTON, D.C. 20001

TO: DIRECTOR, BUREAU OF PUBLIC HEALTH  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09346

8399

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL MARYLAND				STATE MARYLAND COUNTY ANNE ARUNDEL			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN ANNAPOLIS				TOWN PASADENA		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNIE ARUNDEL GEN'L HOSPITAL				STREET ADDRESS (If rural give location) OUTTING & WEISE AVE GREEN HAVEN.			
3. NAME OF DECEASED (Type or Print) ALFRED N. KELLY				4. DATE OF DEATH SEPT 29 1955			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWER		8. DATE OF BIRTH JULY 16, 1890	
				9. AGE last birthday 65 yrs.		10. IF UNDER 1 YEAR Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN KEEPER OWN BUSINESS				11. BIRTHPLACE (State or foreign country) BALTIMORE MD			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U S I I			
13. FATHER'S NAME WILLIAM EDWARD KELLY				14. MOTHER'S MAIDEN NAME CORA MAY BECKLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO				16. SOCIAL SECURITY NO. 212-09-1225			
				17. INFORMANT & ADDRESS MRS MARIE SMITH GREEN HAVEN PASADENA MD			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4201 IMMEDIATE CAUSE (A) Myocardial infarction						5 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery disease						4 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/25, 1955, to 9/29, 1955, that I last saw the deceased alive on 9/29, 1955, and that death occurred at 1:10 P.M. from the causes and on the date stated above. 9/29/55							
SIGNATURE John R. Heblman				DATE SIGNED 9/29/55			
M.D. 90 Cathedral St Annapolis Md				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF OCT 3 1955		NAME OF CEMETERY OR CREMATORY GREEN HAVEN		LOCATION (City, town, or county) (State) GREEN BURNIE MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE OCT 5, 1955		J. O. Daniel		J. W. Burdick		Green Burnie, Md	

# CERTIFICATE OF DEATH

2395

Reg. Dist. No.

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF DEATH

3. SEX  
4. DATE OF BIRTH  
5. PLACE OF BIRTH

6. MARITAL STATUS  
7. OCCUPATION

8. CAUSE OF DEATH (GIVE COMPLETE HISTORY OF DISEASE)

9. MEDICAL HISTORY

10. PRESENT ILLNESS

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF DEATH

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CHURCH OFFICIAL

21. SIGNATURE OF CEMETERY OFFICIAL

22. SIGNATURE OF OTHER OFFICIAL

23. SIGNATURE OF OTHER OFFICIAL

24. SIGNATURE OF OTHER OFFICIAL

25. SIGNATURE OF OTHER OFFICIAL

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36. SIGNATURE OF OTHER OFFICIAL

37. SIGNATURE OF OTHER OFFICIAL

38. SIGNATURE OF OTHER OFFICIAL

39. SIGNATURE OF OTHER OFFICIAL

RECEIVED

OCT 7 1955

BUREAU V. B.

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08342

8341

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (In this place) <u>27 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1007 Smithville Avenue</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Harry W. Kimble</u>				<b>4. DATE OF DEATH</b> (Month) <u>Sept.</u> (Day) <u>24</u> (Year) <u>19 55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 30, 1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unkn</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Kimble</u>				14. MOTHER'S MAIDEN NAME <u>Kate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unkn</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Record</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>known to us since 6/20/53</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized and Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Brain Syndrome associated with Senile Brain Disease</u>							
19a. DATE OF OPERATION <u>  </u>		19b. MAJOR FINDINGS OF OPERATION <u>  </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>  </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>  </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>  </u> <u>  </u> <u>  </u> <u>  </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>  </u>			
<b>22. I hereby certify</b> that I attended the deceased from <u>June 20, 1953</u> , to <u>Sept. 24, 1955</u> , that I last saw the deceased alive on <u>Sept. 24, 1955</u> , and that death occurred at <u>10:40 pm</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. Crownsville, Md.</u>		DATE SIGNED <u>9/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
24. REC'D BY REGISTRAR <u>Sept. 27, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>108 W. Main St Annapolis, Md.</u>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08345

8310

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Del.</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Georgetown</u>		462-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convl. Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>GOVE D LYNCH</u>				<u>Sept. 24, 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 30, 1866</u>	<u>88</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>U. S. Marshall</u>		<u>U S Gov.</u>		<u>Del.</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Joshua Lynch</u>				<u>Jane E. Dutton</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<u>Gove Saulsbury, Annapolis, Maryland</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u></u>						<u>UNKNOWN</u>	
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u></u>						<u>UNKNOWN</u>	
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. of work <input type="checkbox"/> et work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Aug.</u>, 19<u>55</u>, to <u>SEPT.</u>, 19<u>55</u>, that I last saw the deceased alive on <u>23 SEPT.</u>, 19<u>55</u>, and that death occurred at <u>12:55 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Edward A Beck</u>				<u>9/24/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>Burial</u>				<u>Sept. 26, 55</u>		<u>Union Cemetery</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>SEPT. 24, 55</u>				<u>[Signature]</u>		<u>[Signature]</u>	
<b>DATE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>LOCATION (City, town, or county) (State)</b>	
				<u>HOPPING FUNERAL HOME</u>		<u>ANNAPOLIS, MD.</u>	

42813

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

8310

Dec 14 1955

1. DEATH RECORDING OFFICE OF BALTIMORE

NAME: **John V. S.**  
DATE OF BIRTH: **Jan. 1, 1900**  
PLACE OF BIRTH: **St. Louis, Mo.**  
OCCUPATION: **Engineer**

2. DEATH RECORDING OFFICE OF BALTIMORE

NAME: **John V. S.**  
DATE OF BIRTH: **Jan. 1, 1900**  
PLACE OF BIRTH: **St. Louis, Mo.**  
OCCUPATION: **Engineer**

3. DEATH RECORDING OFFICE OF BALTIMORE

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72. DEATH RECORDING OFFICE OF BALTIMORE

BUREAU V. S.

SEP 27 1955

RECEIVED

RECEIVED

## No. 21.....

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02340

2311

RECEIVED BY AIR MAIL

TO THE DIRECTOR, BUREAU OF INVESTIGATION

FROM THE DIRECTOR, BUREAU OF INVESTIGATION

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

BUREAU V. H.

SEP 15 1955

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08347

8312

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>5 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Beverly Beach (Mayo, P.O.)</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>				STREET ADDRESS (If rural give location) <u>318 Lake View Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>SOPHIE MABLE MOORE</u> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 6th, 19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Dec. 3rd, 1889</u>		<b>9. AGE last birthday</b> <u>66</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Uriah Heeter</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Elizabeth Nesline</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579-07-2630</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>John R. Moore, Beverly Beach, Mayo P.O., Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>199.9 IMMEDIATE CAUSE</b> (A) <u>Anoxia</u>				<u>3 wks</u>			
<b>ANTECEDENT CAUSE(S)</b> (B) <u>Carcinomatosis</u>				<u>2 yrs</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (C) <u>Probably Granulosa cell Carcinoma</u>				<u>Unknown</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>9</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Jan. 10th, 19 55</u> , to <u>Sept. 5th, 19 55</u> , that I last saw the deceased alive on <u>Sept. 5th, 19 55</u> , and that death occurred at <u>12:25 AM</u> , from the causes and on the date stated above. <u>9/6/55</u>							
<b>SIGNATURE</b> <u>Joseph C. Shuckman M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>69 Franklin, Annapolis, Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Sept. 9th, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cem.</u>		<b>LOCATION</b> (City, town, county) (State) <u>Colmar Manor, Pr. Geo. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Sept. 9, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Wm. J. French</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Company, Riverdale, Md.</u>			



NOTED/RECEIVED

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
SEP 9 1955

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

0315

1955

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. MARITAL STATUS

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INVESTIGATOR

20. SIGNATURE OF SUPERVISOR

21. SIGNATURE OF CHIEF OF BUREAU

22. SIGNATURE OF ASSISTANT CHIEF OF BUREAU

23. SIGNATURE OF DEPUTY ASSISTANT CHIEF OF BUREAU

24. SIGNATURE OF SPECIAL AGENT IN CHARGE

25. SIGNATURE OF FIELD OFFICE

26. SIGNATURE OF LABORATORY

27. SIGNATURE OF MEDICAL EXAMINER

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37. SIGNATURE OF OPTICIAN

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39. SIGNATURE OF VETERINARIAN

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INSTRUCTIONS

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

08348

Reg. Dist. No. 21

8313

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CROWNSVILLE</u> X		STREET ADDRESS (if rural give location) <u>1</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. GENI HOSP.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>HENRY</u> <u>MUTH</u>				<u>Sept. 23, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. (SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>6-14-07</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hospital attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Muth</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>John Muth 12127. Ellwood Ave.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>1 month</u>			
584X IMMEDIATE CAUSE (A) <u>UREMIA</u>							
ANTECEDENT CAUSE(S) DUE TO <u>hepato-renal syndrome.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>cholecystitis cholelithiasis + cholelithiasis</u>							
19a. DATE OF OPERATION <u>8-30-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>" "</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-30-55</u> , 19 <u>55</u> , to <u>9-23-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-23-55</u> , 19 <u>55</u> , and that death occurred at <u>3:18 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gene F. Wilkins</u>		M.D. <u>3:18 A.M.</u>		ADDRESS (Street, city, town, state) <u>98 Cathedral St Annapolis Md.</u>		DATE SIGNED <u>9/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>John J. French</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Miller</u>		ADDRESS <u>2334 Jefferson St</u>	
DATE <u>Sept 26, 1955</u>							

CERTIFICATE OF DEATH

8818

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. DATE OF DEATH: [illegible]  
10. SIGNATURE OF PHYSICIAN: [illegible]  
11. SIGNATURE OF REGISTRAR: [illegible]  
12. SIGNATURE OF WITNESSES: [illegible]

BUREAU V. B.

SEP 27 1955

RECEIVED

NOTIFICATION OF DEATH TO THE DISTRICT OF COLUMBIA  
The following information is being furnished to the District of Columbia Department of Health for their records:  
Name of Deceased: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Death: [illegible]  
Cause of Death: [illegible]  
Place of Death: [illegible]  
Signature of Registrar: [illegible]  
Date: [illegible]

8342

08349

Item 18 Film 8187 10-17-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 22

## 1. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Balto.-Washington Expressway

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D.C. COUNTY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN WASHINGTON 47X-3

STREET ADDRESS (If rural, give location)

320 LIVINGSTON TERRACES E

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HAROLD

O'KEEFE

4. DATE OF DEATH

(Month)

(Day)

(Year)

9

17

19

55

## 5. SEX:

M

## 6. COLOR OR RACE

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

## 8. DATE OF BIRTH:

8-8-01

## 9. AGE last birthday:

54

yrs.

## IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS. Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

PSYCHIATRIC

## 10b. KIND OF BUSINESS OR INDUSTRY:

SOCIAL WORKER

## 11. BIRTHPLACE (State or foreign country):

MARYLAND

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

SPENCER O'KEEFE

## 14. MOTHER'S MAIDEN NAME:

LILLIAN RYAN

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Mrs Loretto G. O'Keefe 320 Livingston Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

Arteriosclerotic cardiovascular disease

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,

(b)

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Paul F. Men

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

9-18-55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Removal

## DATE THEREOF

9/18/55

## NAME OF CEMETERY OR CREMATORY

Washington, D.C.

(State)

## DATE REC'D BY LOCAL REG.

Sept. 20, 1955

## REGISTRAR'S SIGNATURE

Clara Stashup

## 24. FUNERAL DIRECTOR

Spencer Hollins 3821-17th St. N.W.

## ADDRESS

Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1955

BUREAU V. S.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8343

08350

26

## CERTIFICATE OF DEATH

Film G 186, 9-22-55 Item 13 bh

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		STATE <u>Md</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Shady Side</u>		OR TOWN <u>Shady Side (rural)</u>		OR TOWN <u>Shady Side (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>William Franklin Parks</u>				<u>Sept 6 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 30, 1893</u>	9. AGE last birthday <u>63</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>water man</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Cecil, Md</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>William Parks</u>				14. MOTHER'S MAIDEN NAME <u>Miss Rebecca Lyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Lester Lyles, Pineapple</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
ANTECEDENT CAUSE(S) DUE TO <u>with generalized metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Sept 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>55</u> , and that death occurred at <u>2:40</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James D. Mouton</u>				ADDRESS (Street, city, town, state) <u>Pineapple, Md</u>		DATE SIGNED <u>9/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Trunk</u>		LOCATION (City, town, or county) <u>Galumville, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Ada Belle Dent</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. O. Headey &amp; Son</u>		ADDRESS <u>Galumville, Md</u>	
DATE <u>Sept. 13, 1955</u>							

CERTIFICATE OF DEATH

John J. ...  
Maryland

John J. ...  
Maryland

John J. ...  
Maryland

BUREAU V. S.

SEP 13 1953

RECEIVED

John J. ...  
Maryland



8344

08351

Reg. Dist. 24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Pasadena</b>	LENGTH OF STAY (in this place) <b>5 hrs.</b>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Woodenburg</b> <b>03X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Stoney Creek Pawhattan Beach</b>		STREET ADDRESS (If rural, give location) <b>Hanover Pike.</b> ✓	
3. NAME OF DECEASED: (Type or Print) <b>Ruth Mary Peltzer</b>		4. DATE OF DEATH <b>September 11th.</b> 19 <b>55</b>	
5. SEX: <b>F.</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>7/23/41</b>
9. AGE last birthday: <b>14</b> yrs.		10. BIRTHPLACE (State or foreign country): <b>Reiterstown Md.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Pupil</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Spurgeon Peltzer</b>		14. MOTHER'S MAIDEN NAME: <b>Grace Hellwig</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Daniel M. Peltzer, Reisterstown, Md.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		Sudden
(a) <b>Accidental Drowning</b> Immediate cause DUE TO		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <b>INJURY Stoney Creek Pawhattan Beach, Pasadena, A.A. Md.</b>	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>9/11/55 5. P. M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Drowning.</b>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Mustose K. Peltzer</i>	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	DATE SIGNED <b>9/11/55</b>
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>Sept. 14/55</b>	NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>
LOCATION (City, town, or county) (State) <b>Boring, Md.</b>	24. FUNERAL DIRECTOR <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>	ADDRESS
DATE REC'D BY LOCAL REG. <b>9-12-55</b>	REGISTRAR'S SIGNATURE <i>L. J. Beatty</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

SEP 14 1955

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09360

8314

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>2 days</u>		TOWN <u>Arnold (Rural)</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Anne Arundel General Hosp-</u>				<u>Route 1-Box 27</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>JAMES G. PUMPHREY</u>				<u>SEPT 30 1955</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>July 19, 1893</u>	
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
<u>62</u> yrs.		Months Days		Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Inspector</u>				<u>Foot Meade</u>		<u>Baltimore, Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b>			
<u>U.S.A.</u>				<u>John Henry Pumphrey</u>			
<b>14. MOTHER'S MAIDEN NAME</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If Yes, give war or dates of service)			
<u>Mary Turpin</u>				<u>Yes Mexican Invasion Unknown</u>			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT &amp; ADDRESS</b>			
<u>Unknown</u>				<u>Catherine A. Pumphrey Route 1 Box 27 Arnold, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b>						<b>CEREBRAL VASCULAR ACCIDENT</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>						<b>9/28/55</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b>						<b>ARTERIOSCLEROSIS, GENERALIZED</b>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
						<b>UNKNOWN</b>	
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<input type="checkbox"/>							
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>9/28</u>, 19<u>55</u>, to <u>9/30</u>, 19<u>55</u>, that I last saw the deceased alive on <u>9/30/55</u>, 19<u>55</u>, and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Edward A. Beck</u>				<u>41 Southgate Ave. Annapolis</u>		<u>9/30/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>				<u>Glen Haven Cemetery</u>		<u>Glen Burnie, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Oct. 5, 1955</u>				<u>W. D. Daniel</u>		<u>119 S. Lightfoot - The Burnie, Md.</u>	

BUREAU V. S.

OCT 2 1955

RECEIVED

8315

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08352

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE	COUNTY <i>47X-3</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Annapolis Harbor</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Washington D.C.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. Gen Hosp DOA</i>		STREET ADDRESS (If rural, give location) <i>712-Portland St. SE</i>	
3. NAME OF DECEASED:	(First) <i>Christine</i>	(Middle) <i>Schantz</i>	(Last) <i>Schantz</i>
(Type or Print)		4. DATE OF DEATH	(Month) <i>9</i> (Day) <i>25</i> (Year) <i>1955</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>	8. DATE OF BIRTH: <i>July 24-1890</i>
9. AGE last birthday: <i>65</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Germany</i>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Horsewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Fritz</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>9</i>		16. SOCIAL SECURITY No.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Fred Schantz</i>		<i>712-Portland St. SE, Wash. D.C.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
260X Immediate cause (a) <i>Coronary Arteriosclerosis</i>		
Antecedent cause(s) (b) <i>Arteriosclerosis</i>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <i>9-20-55</i>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *[Signature]* CHIEF MEDICAL EXAMINER DATE SIGNED *9/25/55*  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>9-25-55</i>	NAME OF CEMETERY OR CREMATORY: <i>Cedar Hill</i>	LOCATION (City, town, or county) (State): <i>Switzland Md</i>
DATE REC'D BY LOCAL REG: <i>Sept. 25, 1955</i>	REGISTRAR'S SIGNATURE: <i>[Signature]</i>	24. FUNERAL DIRECTOR: <i>Simmons Bros.</i>	ADDRESS: <i>1661- Good Hope Rd. Washington D.C.</i>

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02558

8315

BUREAU V. 2

SEP 27 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08353

8316

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		STATE <i>Md.</i> COUNTY <i>C. A.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		TOWN <i>Annapolis</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. General</i>		STREET ADDRESS (If rural give location) <i>A. A. General Hosp.</i>		DATE OF DEATH <i>9 7 1955</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Baby</i> (First) <i>Simmons</i> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
SEX <i>M</i>		COLOR OR RACE <i>Col</i>		SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>		DATE OF BIRTH <i>9-6-55</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stanley Simmons</i>				14. MOTHER'S MAIDEN NAME <i>Joan Belt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Joan Belt - Annapolis, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <i>7625 asphyxia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO <i>Atelectasis, congenital</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Pneumonia</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>9/6</i> , 19 <i>55</i> , to <i>9/7</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9/6</i> , 19 <i>55</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above. <i>9/7/55</i> SIGNATURE <i>Joseph B. Shukla M.D.</i> ADDRESS (Street, city, town, state) <i>69 Franklin, Annapolis, Md.</i> DATE SIGNED <i>9/7/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-13-55</i>		NAME OF CEMETERY OR CREMATORY <i>Brewer Hill Annapolis, Md.</i>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <i>Sept. 20, 1955</i>		REGISTRAR'S SIGNATURE <i>Wm. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		ADDRESS <i>Annapolis, Md.</i>	

CERTIFICATE OF DEATH

8318

Name of Deceased *John J. Jones*  
 Date of Death *Sept 13-22*  
 Place of Death *Home*  
 Cause of Death *Heart Failure*  
 Age *75*  
 Sex *M*  
 Race *W*  
 Occupation *Retired*  
 Signature of Physician *[Signature]*  
 Signature of Registrar *[Signature]*  
 Date of Registration *Sept 20-22*  
 Place of Registration *Baltimore*

BUREAU V. S.

SEP 20 1922

RECEIVED

Received from *John J. Jones*  
 Date *Sept 13-22*  
 Amount *\$100.00*  
 For *Funeral Expenses*

58-55

8345

09367

Reg. Dist.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 24

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Anne Arundel</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Same</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Glen Burnie</u>			CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Same</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Georgia Ave. N.W.</u>			STREET ADDRESS (If rural, give location) <u>Same</u>		
3. NAME OF DECEASED: (Type or Print) <u>Harry Elmer Sneed</u>			4. DATE OF DEATH <u>Sept. 30 19 55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10/14/11</u>		9. AGE last birthday: <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if regular) <u>William employee of U.S.A.</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Harry B. Sneed</u>			14. MOTHER'S MAIDEN NAME: <u>Dorothy Hancock</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY No.: <u>213-12-4067</u>		17. INFORMANT & ADDRESS: <u>Mrs. Fannie Sneed (wife)</u>

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Strangulation, self inflicted by hanging himself</u> DUE TO Antecedent cause(s) (b) <u>with a clothes' line, around his neck and fasten-</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>ed to the main beam of his home.</u>				Sudden	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)			
<u>Glen Burnie</u>	<u>A.A.</u>	<u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9/30/55 9 P.M. M</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? (it to a beam.) <u>Placing a rope around neck and fastening</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Walter R. Paubendred</u>		M. D. <u>CHIEF MEDICAL EXAMINER</u> <u>DEPUTY MEDICAL EXAMINER</u> <u>ASSISTANT MEDICAL EXAM.</u>		DATE SIGNED <u>10/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>10/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	LOCATION (City, town, or county) (State) <u>Glen Burnie, AA Co., Md.</u>		
DATE REC'D BY LOCAL REG. <u>Oct 4, 1955</u>	REGISTRAR'S SIGNATURE <u>R. J. De Alba</u>	24. FUNERAL DIRECTOR <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 7 1955

BUREAU A. S.

8346

## CERTIFICATE OF DEATH

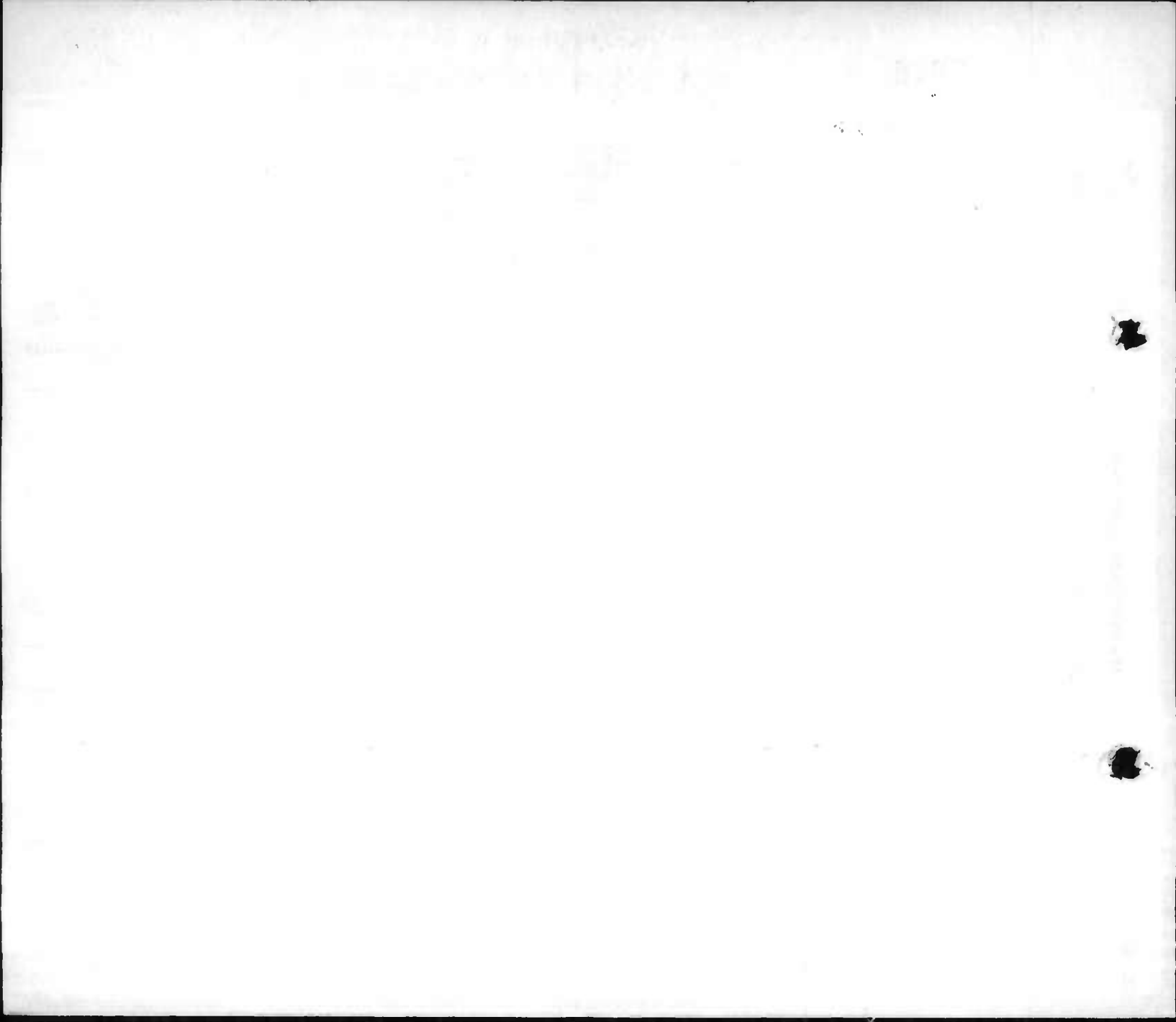
Reg. Dist. No.

y. The

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and let this certificate must be with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print) <i>Mrs. Katherine Marie Snyder</i>			2. DATE OF DEATH <i>Sept. 4, 1955</i>		
3. PLACE OF DEATH: A. <i>Baltimore City, Maryland Linthicum Hgts. Md.</i>			4. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>a.d., Linthicum</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>X</i> <i>Linthicum Heights, Md.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Linthicum Heights, Md.</i>		
6. Length of stay in Baltimore <i>00</i> <i>A.A. County 27 yr.</i>			D. STREET ADDRESS (If rural, give location) <i>320 E. Maple Road.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 3, 1898</i>	9. AGE (In years last birthday) <i>57</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>John Abar</i>			14. MOTHER'S MAIDEN NAME <i>Josephine S. Gregory</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> <i>none</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT ADDRESS <i>Lillian I. Shaw, 320 E. Maple Rd.</i>			18. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>155X</i>			(A) <i>Cirrhosis of Liver</i> <i>6 mo.</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) <i>Primary Carcinoma of Liver</i> <i>3 mo.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION <i>7-30-55</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diagnostic</i>	
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>July 7, 1955</i> to <i>Sept. 4, 1955</i> , that (I) (we) last saw the deceased alive on <i>Sept. 3, 1955</i> , and that death occurred at <i>—</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Dwight M. Currie</i>		23B. ADDRESS <i>11 E. Chase St. Baltimore 2 Md.</i>		23C. DATE SIGNED <i>9-4-55</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>9-7-55</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Corrigan</i>	
24D. LOCATION (City, town or county) (State) <i>Baltimore Md.</i>					
25. FUNERAL DIRECTOR <i>Wm Cook Inc 1217 St Paul St</i>					





**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08355

8317

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
<u>10</u> TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>51</u> <u>U.S. NAVAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>1914 West St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Rosie</u> (Middle) <u>Etta</u> (Last) <u>SPRIGGS</u>				(Month) <u>Sept.</u> (Day) <u>8</u> (Year) <u>19 55</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>N.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Land</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Erin WHITE</u>				14. MOTHER'S MAIDEN NAME <u>Emma JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>USNH Records</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>450.0</u> <u>General arteriosclerosis</u> <u>450</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Indef.</u>			
ANTECEDENT CAUSE(S) (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>DUE TO</u>							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>6-28</u>, 19 <u>55</u>, to <u>9-8</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>9-8</u>, 19 <u>55</u>, and that death occurred at <u>8:00AM</u>, from the causes and on the date stated above.</b>							
SIGNATURE <u>A.J. Weiss</u> <u>LT MC USN</u>				ADDRESS (Street, city, town, state) <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, Md.</u> DATE SIGNED <u>9-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>16-1082 Washington St. Annapolis, Md.</u>	

## 44

44-38861-248

65-11405

BUREAU A. S.

9-11-22 Bremer Hill Cemetery, N.Y.  
William James - 1880  
Cemetery, N.Y.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8347

## CERTIFICATE OF DEATH

08356

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>New York</u>		COUNTY <u>Queens</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port G.G. Meade</u>		LENGTH OF STAY (In this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Albans</u>		<u>69X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>115-20 203 Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>BRUCE</u> <u>EDWARD</u> <u>STEINBERG</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>September 14</u> <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>11 September 1955</u>		<b>9. AGE last birthday</b> yrs. <u>3</u>	<b>IF UNDER 1 YEAR</b> Months Days <u>3</u>	<b>IF UNDER 24 HRS.</b> Hours Min. <u>3</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Bob Murray Steinberg</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sherry Sari Richling</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>4 no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Father: Box 245, R.R.#2, Laurel, Maryland</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. IMMEDIATE CAUSE (A)</b> <u>762.5 Anoxia</u>						<u>3 days</u>	
<b>2. ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Atelectasis</u>						<u>3 days</u>	
<b>3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Prematurity</u>						<u>3 days</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>2</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Sept 11</u>, 19<u>55</u>, to <u>Sept 14</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Sept 14</u>, 19<u>55</u>, and that death occurred at <u>2:10 P.M.</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Herbert L. Needleman</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. FORT G.G. MEADE, Maryland</u>		<b>DATE SIGNED</b> <u>14 Sept. 1955</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>15 Sept. 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Ohev Shalom Cem.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>15 Sept. 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>HARRY CARSCH, CWO, USA</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lewis Funeral Home, 200 Eutaw Pl., Balto.</u>			

2095211351



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INSTRUCTIONS

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

08357

Reg. Dist. No. 21

8318

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis, Md.</u>		<u>D.O.A.</u>		TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>Oberry Court</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Iris</u>		(Middle) <u>Yvonne</u>		(Last) <u>SUMLER</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>July 24, 1955</u>	
				9. AGE last birthday <u>1</u> yrs.		IF UNDER 1 YEAR <u>1</u> Months <u>22</u> Days	
						IF UNDER 24 HRS. <u>19</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jonas Roosevelt SUMLER</u>				14. MOTHER'S MAIDEN NAME <u>Mary JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>U. S. Naval Hospital Annapolis, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia 4 wks</u>				Number 491			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>dead on arrival at U.S. Naval Hospital Annapolis, Md.</u> to <u>11:00</u> , that I last saw the deceased <u>Sept. 15, 1955</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. R. PETERS, Lt. MC, USN.</u>				DATE SIGNED <u>Sept. 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reed</u>		ADDRESS <u>102 W. Wash St Annapolis, Md.</u>	



# CERTIFICATE OF DEATH

Reg. Dist. No.

2129

1. REGISTRATION NUMBER OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF REGISTRAR

11. DATE OF REGISTRATION

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

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BUREAU V. S.

SEP 20 1955

RECEIVED

William Hill  
1-17-55



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08359

8349

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>California</u> COUNTY <u>Orange</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Port George G. Meade</u>		<u>4 1/2 mos.</u>		TOWN <u>Orange</u>		<u>43X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>R.#2, 638 West Collins Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Cheryl Ann Thompson</u>				<u>September 21 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>May 7, 1955</u>	ys. <u>4 1/2</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Ronald Louis Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Enid Cleveland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Father, R.2, 638 Collins Avenue, West Orange, California</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1. IMMEDIATE CAUSE (A) <u>Pneumonia Pneumonia</u>						<u>4 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO <u>Congestive Heart Failure</u>						<u>4 months</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Congenital Heart Disease</u>						<u>4 months</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		<u>None</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>19 Sept</u> , 19 <u>55</u> , to <u>21 Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>21 Sept</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Needleman</u> <u>MD MC</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>HERBERT L. NEEDLEMAN, 1ST MD, MC</u>				<u>Fort G.G. Meade, Md.</u>		<u>September 21, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Private Removal</u>		<u>9-21-55</u>		<u>Loma Vista</u>		<u>Brea, Calif.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>21 Sep 55</u>		<u>HARRY CARSON, CWO, USA</u>		<u>WM. COOK, INC. BALTO., MD</u>			
DATE							

2055191404

100-333

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

# CERTIFICATE OF DEATH

1955

Reg. Dist. No. 1

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. PLACE OF BIRTH (City, town, village, county, state)

5. DATE OF DEATH (Month, day, year)

6. TIME OF DEATH (Hour, minute)

7. PLACE OF DEATH (City, town, village, county, state)

8. CAUSE OF DEATH (Immediate cause, underlying cause, contributing cause)

9. MANNER OF DEATH (Natural, Accidental, Homicide, Suicide, Undetermined)

10. SIGNATURE OF PHYSICIAN (Name, Title, Address)

11. SIGNATURE OF REGISTRAR (Name, Title, Address)

12. SIGNATURE OF WITNESSES (Name, Title, Address)

13. SIGNATURE OF DECEASED (Name, Title, Address)

14. SIGNATURE OF NEXT OF KIN (Name, Title, Address)

15. SIGNATURE OF BURIAL OFFICIAL (Name, Title, Address)

16. SIGNATURE OF CHURCH OFFICIAL (Name, Title, Address)

17. SIGNATURE OF FUNERAL HOME (Name, Title, Address)

18. SIGNATURE OF OTHER (Name, Title, Address)

19. SIGNATURE OF OTHER (Name, Title, Address)

20. SIGNATURE OF OTHER (Name, Title, Address)

21. SIGNATURE OF OTHER (Name, Title, Address)

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56. SIGNATURE OF OTHER (Name, Title, Address)

57. SIGNATURE OF OTHER (Name, Title, Address)

58. SIGNATURE OF OTHER (Name, Title, Address)

BUREAU V. B.

SEP 28 1955

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08358

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grnold Md</u> TOWN <u>Grnold Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 day</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>AA.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grnold</u> TOWN <u>Grnold</u> STREET ADDRESS (If rural give location) <u>X</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Joseph</u> (Middle) <u>Hayward</u> (Last) <u>Todd Sr</u>				4. DATE OF DEATH (Month) <u>9</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1900</u>	9. AGE last birthday <u>55</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l Mgr. Elevator</u>		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l Mgr. Elevator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
13. FATHER'S NAME <u>Joseph Todd</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>170-01-1192</u>			
17. INFORMANT & ADDRESS <u>San Joseph H Todd Jr</u>				18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO <u>Coronary Thrombosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>was hospitalized S Balt. Hosp Jan 1953</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>deceased at that time</u>			
22. I hereby certify that I attended the deceased from <u>Sept 22 1955</u> to <u>Sept 22 1955</u> , that I last saw the deceased alive on <u>Sept 22 1955</u> , and that death occurred at <u>4:30 am</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. Allen</u>				ADDRESS (Street, city, town, state) <u>62 Cathedral St</u>		DATE SIGNED <u>9-22-55</u>	
23. BURIAL, CREATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. Seaberg</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thm. J. Tickner &amp; Sons - Balt</u>			

# CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

408258

0018

AT HOME, RESIDENCE OF THE DECEASED

44

DATE OF DEATH

1955

DATE OF DEATH

1955

DATE OF DEATH

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PHOTOGRAPH

1

DATE OF DEATH

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 8

SEP 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8350		08360	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 24			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Same</b>	COUNTY <b>Id.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<b>X</b> TOWN <b>Glen Burnie</b>	<b>2 years</b>	TOWN <b>Id.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>501 Monroe Circle</b>		STREET ADDRESS <b>Id.</b> (If rural, give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<b>Aldona Wallrath</b>		<b>Sept. 10 19 55</b>	
5. SEX: <b>F.</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>3/29/29</b>
9. AGE last birthday: <b>26</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Glen Burnie, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Austin J.F. Dunn</b>		14. MOTHER'S MAIDEN NAME: <b>Doris School</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>213-26-6477</b>	
17. INFORMANT & ADDRESS: <b>Robert Wallrath, (husband)</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
7544 Immediate cause (a) <b>Thrombo-Embolism</b>			<b>Sudden.</b>
Antecedent cause(s) (b) <b>Congenital Heart Disease</b>			<b>Life.</b>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <b>6</b>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Gustave H. Roeder MD</b>		CHIEF MEDICAL EXAMINER <b>9/11/55</b>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>9/13/55</b>	NAME OF CEMETERY OR CREMATORY: <b>Glen Haven Memorial</b>	LOCATION (City, town, or county) (State): <b>Glen Burnie, AA Co., Md.</b>
DATE REC'D BY LOCAL REG. <b>Sept. 12. 55</b>	REGISTRAR'S SIGNATURE <b>L. J. DeAlba</b>	24. FUNERAL DIRECTOR <b>Hopping and Kirkley, Glen Burnie, Md.</b>	

BUREAU V. S.

SEP 16 1955

RECEIVED



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08361

8351

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>42yrs. 4mos.</u>		CITY OR TOWN <u>Jessups</u>		<u>13X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>		STREET ADDRESS <u>None listed</u>		(If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Maggie Warner</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9 19 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>72?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>David Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Henson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>48 hours</u>			
331X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebrovascular Accident</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive heart disease</u>							
19a. DATE OF OPERATION <u>- - - -</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - -</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - - - M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>- - - -</u>			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>53</u> , to <u>9/19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>55</u> , and that death occurred at <u>8:40a.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Arnold H. Eichert</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>9/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		LOCATION (City, town, or county) (State) <u>Annapolis Jet Md.</u>	
24. REC'D BY REGISTRAR <u>Sept 22</u>		REGISTRAR'S SIGNATURE <u>K M Jace</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Hignett</u>		ADDRESS <u>Elliot City</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1951

1. NAME - HARRISON, JOHN

2. SEX - Male

3. AGE - 75

4. RACE - White

5. BIRTH DATE - 1876

6. BIRTH PLACE - Baltimore, Md.

7. DEATH DATE - 1951

8. DEATH PLACE - Baltimore, Md.

9. CAUSE OF DEATH - Heart Disease

10. MANNER OF DEATH - Natural

11. SIGNATURE - J. H. Harrison

12. SIGNATURE - J. H. Harrison

13. SIGNATURE - J. H. Harrison

14. SIGNATURE - J. H. Harrison

15. SIGNATURE - J. H. Harrison

16. SIGNATURE - J. H. Harrison

17. SIGNATURE - J. H. Harrison

18. SIGNATURE - J. H. Harrison

19. SIGNATURE - J. H. Harrison

20. SIGNATURE - J. H. Harrison

21. SIGNATURE - J. H. Harrison

22. SIGNATURE - J. H. Harrison

23. SIGNATURE - J. H. Harrison

24. SIGNATURE - J. H. Harrison

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31. SIGNATURE - J. H. Harrison

32. SIGNATURE - J. H. Harrison

33. SIGNATURE - J. H. Harrison

34. SIGNATURE - J. H. Harrison

35. SIGNATURE - J. H. Harrison

1. NAME - HARRISON, JOHN

2. SEX - Male

3. AGE - 75

4. RACE - White

5. BIRTH DATE - 1876

6. BIRTH PLACE - Baltimore, Md.

7. DEATH DATE - 1951

8. DEATH PLACE - Baltimore, Md.

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10. MANNER OF DEATH - Natural

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15. SIGNATURE - J. H. Harrison

16. SIGNATURE - J. H. Harrison

17. SIGNATURE - J. H. Harrison

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21. SIGNATURE - J. H. Harrison

22. SIGNATURE - J. H. Harrison

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32. SIGNATURE - J. H. Harrison

33. SIGNATURE - J. H. Harrison

34. SIGNATURE - J. H. Harrison

1. NAME - HARRISON, JOHN

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3. AGE - 75

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7. DEATH DATE - 1951

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15. SIGNATURE - J. H. Harrison

16. SIGNATURE - J. H. Harrison

17. SIGNATURE - J. H. Harrison

18. SIGNATURE - J. H. Harrison

19. SIGNATURE - J. H. Harrison

20. SIGNATURE - J. H. Harrison

21. SIGNATURE - J. H. Harrison

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33. SIGNATURE - J. H. Harrison

34. SIGNATURE - J. H. Harrison

1. NAME - HARRISON, JOHN

2. SEX - Male

3. AGE - 75

4. RACE - White

5. BIRTH DATE - 1876

6. BIRTH PLACE - Baltimore, Md.

7. DEATH DATE - 1951

8. DEATH PLACE - Baltimore, Md.

9. CAUSE OF DEATH - Heart Disease

10. MANNER OF DEATH - Natural

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12. SIGNATURE - J. H. Harrison

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14. SIGNATURE - J. H. Harrison

15. SIGNATURE - J. H. Harrison

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17. SIGNATURE - J. H. Harrison

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33. SIGNATURE - J. H. Harrison

34. SIGNATURE - J. H. Harrison

BUREAU V. S.

SEP 27 1951

RECEIVED

2155 K 18 For

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8352  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08362  
 Reg. Dist. 73  
 No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Anne Arundel</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Linthicum Heights</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <b>Linthicum Heights</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>714 S. Camp Meade Road</b>				STREET ADDRESS (If rural, give location) <b>714 S. Camp Meade Road</b>			
3. NAME OF DECEASED: (Type or Print) <b>BARBARA JEAN LOVELL WARREN</b>				4. DATE OF DEATH <b>9/8/55</b> 19			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>12/25/16</b>	9. AGE last birthday: <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Gibson City, Illinois</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Frank Blair Lovell</b>				14. MOTHER'S MAIDEN NAME: <b>Helen L. Boewster</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>213-14-4181</b>		17. INFORMANT & ADDRESS: <b>Mr. S.E. Warren, Husband</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<b>420.1</b> Immediate cause (a)..... <b>Dissecting aneurysm of coronary artery</b> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Paul K. Men</i>		M.D. <i>Paul K. Men</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9/9/55</b> ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Crementation</b>		DATE THEREOF <b>Sept. 10/55</b>		NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>September 10, 1955</b>		REGISTRAR'S SIGNATURE <i>Caldwell Harduff</i>		24. FUNERAL DIRECTOR <i>R. H. Kingston</i>		ADDRESS <i>Shen Burns, Md.</i>	

BUREAU V. 3

SEP 15 1955

RECEIVED

8353

## CERTIFICATE OF DEATH

08363

Reg. Dist. No. 24

## 1. PLACE OF DEATH

COUNTY Anne Arundel MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN x Riviera Beach

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

00 Wanda Rd. Pasadena, Md

3. NAME OF  
DECEASED  
(Type or Print)

(First) JOHN

(Middle) JOSEPH

(Last) WEBER

4. DATE  
OF  
DEATH

(Month) 9 (Day) 2 (Year) 1955

## 5. SEX

M

6. COLOR OR  
RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Married

## 8. DATE OF BIRTH

8/2/1891

## 9. AGE last birthday

64 yrs.

## IF UNDER 1 YEAR

Months Days

## IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Barber

10b. KIND OF BUSINESS  
OR INDUSTRY

Camp Meade Md

## 11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U.S.

## 13. FATHER'S NAME

Matthew Weber

## 14. MOTHER'S MAIDEN NAME

Mary Shell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

No None

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Sylvia Ganzhorn

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased  
alive on 19, and that death occurred at 11:30 M. from the causes and on the date stated above.

## SIGNATURE

Joseph Taler

## ADDRESS (Street, city, town, state)

102 Balto-Annap. Blvd.  
M.D. M.E. Glen Burnie, Md.

## DATE SIGNED

9/3/1955

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

BURIAL

## DATE THEREOF

Sept. 6, 1955

## NAME OF CEMETERY OR CREMATORY

New Cathedral

## LOCATION (City, town, or county)

Balto

## (State)

Md.

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

DATE Sept. 6, 1955

L. J. DeAlto

## 25. FUNERAL DIRECTOR'S SIGNATURE

Gerry J. Ronce 4001 Ritchie Hwy

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

8253

Form 10-1-35

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

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39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

BUREAU V. 8

SEP 2 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

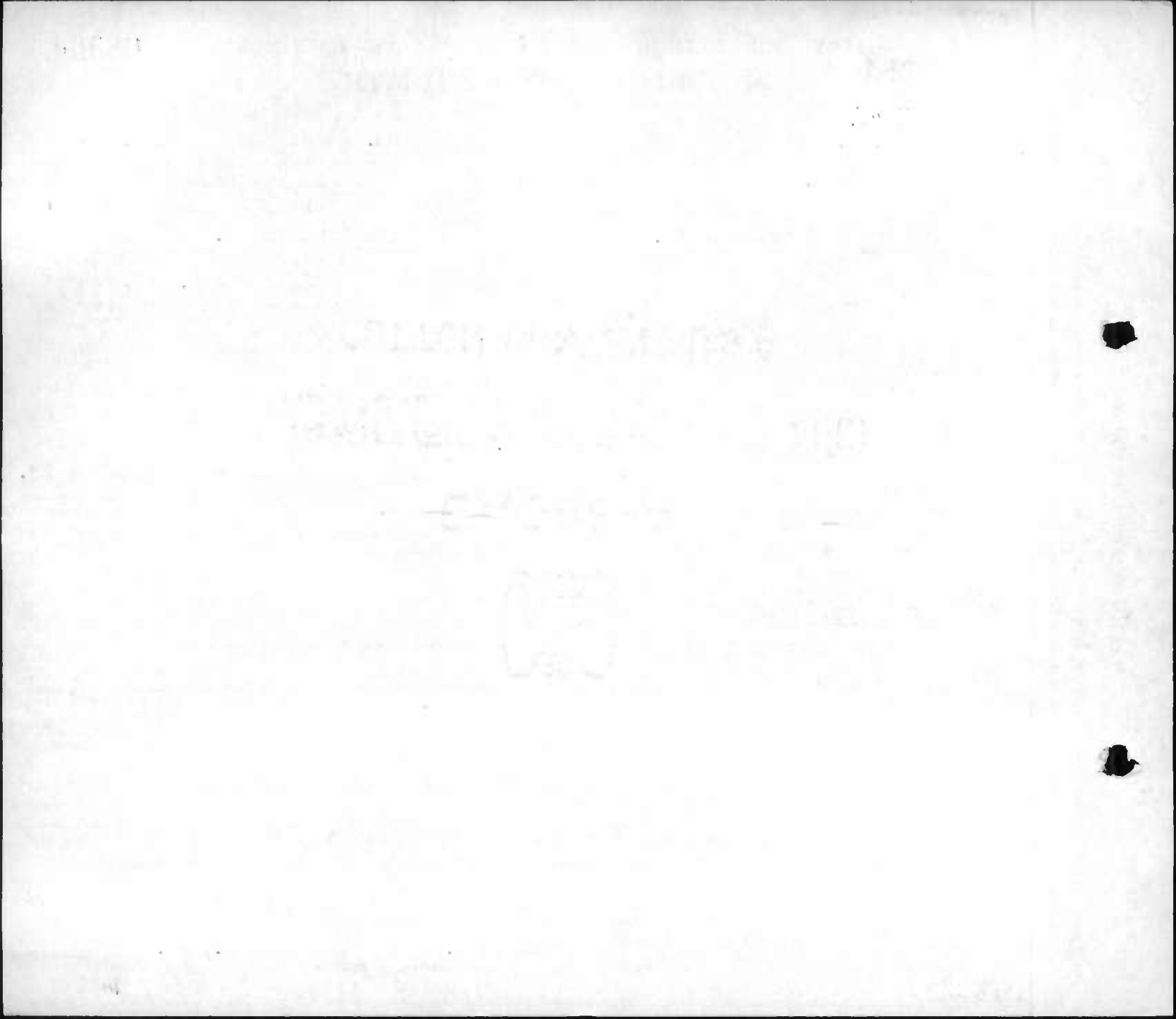
08364

8354

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>A. A.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>A. A.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Linthicum Heights</u>		TOWN <u>Linthicum Heights</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>00</u> <u>104 Catalpha Rd.</u>		<u>104 Catalpha Rd.</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>CHARLES C. WILLIAMS</u>		DATE OF DEATH: <u>Sept. 23, 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>March 3, 1886</u>
9. AGE last birthday		10. DATE OF BIRTH:	
<u>69</u> yrs.		<u>March 3, 1886</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Washington, D. C.</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Charles Williams</u>		<u>Ida Schaffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>9</u>			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mrs. A. C. Christopher - 104 Catalpha Rd.</u>		<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p><u>260X</u> IMMEDIATE CAUSE (A) <u>acute heart failure &amp; pulmonary</u></p> <p>ANTECEDENT CAUSE (S) DUE TO <u>edema</u></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO</p> <p>(C)</p>	
19. DATE OF OPERATION:		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>			
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. I hereby certify that I attended the deceased from <u>Sept 23, 1955</u> , to <u>Sept 23, 1955</u> , that I last saw the deceased alive on <u>Sept 23, 1955</u> , and that death occurred at <u>12:45 A.</u> from the causes and on the date stated above.	
21a. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21b. WHERE DID (City or town) (County) (State)	
<u>1215 N. Lincoln St.</u>		<u>Balto., Md.</u>	
21c. TIME (Month) (Day) (Year) (Hour) OF INJURY		21d. HOW DID INJURY OCCUR?	
<u>Sept 23, 1955</u>		<u>While at work</u>	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. SIGNATURE		21g. DATE SIGNED	
<u>C. Nelson Linthicum</u>		<u>Sept 23, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. NAME OF CEMETERY OR CREMATORY	
<u>Cremation</u>		<u>Green Mount Crem.</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>9/26/55</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR ADDRESS	
<u>September 24, 1955</u>		<u>Wm. J. Liskner &amp; Son, Balto.</u>	
REGISTRAR'S SIGNATURE			
<u>R.W.</u>			



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08365

8355

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY <b>Anne Arundel</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Mayo, Md.</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Anne Arundel</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Mayo, Md.</b> <b>X</b> STREET ADDRESS (If rural give location) <b>1</b>			
3. NAME OF DECEASED (Type or Print) (First) <b>Sylve</b> (Middle) <b>ster</b> (Last) <b>E. Williams</b>				4. DATE OF DEATH (Month) <b>Sept.</b> (Day) <b>17</b> (Year) <b>19 55</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE; MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>11-20-1876</b>	9. AGE last birthday <b>78</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sylvester Williams</b>				14. MOTHER'S MAIDEN NAME <b>Celestia Celt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or omit) <b>9</b>		16. SOCIAL SECURITY NO. <b>578-24-057 A</b>		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.0</b> IMMEDIATE CAUSE (A) <b>Coronary thrombosis</b>						<b>35 days</b>	
ANTECEDENT CAUSE(S) DUE TO <b>Arteriosclerotic heart disease</b>						<b>20 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8-12-55</b> , 19 <b>55</b> , to <b>9-17-55</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9-17-55</b> , 19 <b>55</b> , and that death occurred at <b>3 P</b> .M, from the causes and on the date stated above.							
SIGNATURE <b>Vincent Gough</b> M.D.				ADDRESS (Street, city, town, state) <b>Mayo, Md.</b>		DATE SIGNED <b>9-17-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>SEPT 20, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>George Washington Cem. Riggs Rd. Prince Georges Co. Md.</b>		LOCATION (City, town, or county) (State) <b>254 CARROLL ST. N.W. WASHINGTON, D.C.</b>			
24. REC'D BY REGISTRAR <b>Sept. 19, 1955</b>	REGISTRAR'S SIGNATURE <b>Edward Collins</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Walters</b>		ADDRESS <b>JAROMA PARK 12, D.C.</b>		

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

10830

Reg. No. 12

1. (LOCAL RESIDENTS) NAME OF DECEASED

John A. Smith

2. SEX

Male

3. AGE

45

4. DATE OF BIRTH

1910-10-15

5. PLACE OF BIRTH

Baltimore, Md.

6. OCCUPATION

Teacher

7. MARITAL STATUS

Married

8. NAME OF SPOUSE

John A. Smith

9. NAME OF PHYSICIAN

John A. Smith

10. NAME OF HOSPITAL

John A. Smith

11. NAME OF FUNERAL HOME

John A. Smith

12. NAME OF BURIAL PLACE

John A. Smith

13. NAME OF CEMETERY

John A. Smith

14. NAME OF INTERMENT

John A. Smith

15. NAME OF CREMATION

John A. Smith

16. NAME OF URN

John A. Smith

17. NAME OF CASK

John A. Smith

18. NAME OF COFFIN

John A. Smith

19. NAME OF CASK

John A. Smith

20. NAME OF COFFIN

John A. Smith

21. NAME OF CASK

John A. Smith

22. NAME OF COFFIN

John A. Smith

23. NAME OF CASK

John A. Smith

24. NAME OF COFFIN

John A. Smith

25. NAME OF CASK

John A. Smith

26. NAME OF COFFIN

John A. Smith

27. NAME OF CASK

John A. Smith

28. NAME OF COFFIN

John A. Smith

29. NAME OF CASK

John A. Smith

30. NAME OF COFFIN

John A. Smith

31. NAME OF CASK

John A. Smith

1. (LOCAL RESIDENTS) NAME OF DECEASED

John A. Smith

2. SEX

Male

3. AGE

45

4. DATE OF BIRTH

1910-10-15

5. PLACE OF BIRTH

Baltimore, Md.

6. OCCUPATION

Teacher

7. MARITAL STATUS

Married

8. NAME OF SPOUSE

John A. Smith

9. NAME OF PHYSICIAN

John A. Smith

10. NAME OF HOSPITAL

John A. Smith

11. NAME OF FUNERAL HOME

John A. Smith

12. NAME OF BURIAL PLACE

John A. Smith

13. NAME OF CEMETERY

John A. Smith

14. NAME OF INTERMENT

John A. Smith

15. NAME OF CREMATION

John A. Smith

16. NAME OF URN

John A. Smith

17. NAME OF CASK

John A. Smith

18. NAME OF COFFIN

John A. Smith

19. NAME OF CASK

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91. NAME OF CASK

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100. NAME OF COFFIN

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101. NAME OF CASK

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102. NAME OF COFFIN

John A. Smith

103. NAME OF CASK

John A. Smith

104. NAME OF COFFIN

John A. Smith

105. NAME OF CASK

John A. Smith

106. NAME OF COFFIN

John A. Smith

107. NAME OF CASK

John A. Smith

108. NAME OF COFFIN

John A. Smith

**INSTRUCTIONS**  
**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8356

**CERTIFICATE OF DEATH**

08366

Reg. Dist. No. ....28.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>14X-2</u>	
OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2 mos. 4 days</u>		TOWN <u>Chestertown</u>		STREET ADDRESS (If rural give location) <u>R. D.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS <u>R. D.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Charles Wilson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>9 2 19 55</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Sep.</u>		<b>8. DATE OF BIRTH</b> <u>8/10/80</u>	
<b>9. AGE last birthday</b> <u>75</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farm Work</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>	
<b>13. FATHER'S NAME</b> <u>Henry Wilson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Wilson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unk.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>023X</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Congestive heart failure</u>				<b>4 days</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Syphilis</u>				<b>Known to us since</b> <u>6/30/55</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7/5, 19 55, to 9/2, 19 55, that I last saw the deceased alive on 9/2, 19 55, and that death occurred at 2:15 p.m., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Cherett M. Cadenhead</u> M.D.				<b>DATE SIGNED</b> <u>9/2/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>9/4/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Chestertown Md</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Chestertown Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>9-12-55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>H M Sgee</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Willis Wells</u>		<b>ADDRESS</b> <u>Chestertown Md</u>	

5

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08367

8357

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Glen Burnie, Md.				TOWN Glen Burnie, Md.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		/	
00 306 D Street SW				306 D Street SW			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Lillian (Middle) Zimmerman (Last)				(Month) (Day) (Year)			
				Sept. 20, 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F.	W	Widow	August 5, 1881	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward Boteler				Emily Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				Mrs Wm. Duly, 306 D St. Glen Burnie, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) Hypostatic Pneumonia						3-4 days	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma Breast - metastatic						2 yrs -	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Extensive left femur + pelvis - metastatic							
Structure of left femur - pathologic							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 18, 1955, to Sept 20, 1955, that I last saw the deceased alive on 9/10, 1955, and that death occurred at 2 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Chas. S. Ball				M.D. Lanthier Md.		9/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/23/55		Trinity Church Cemetery		Anne Arundel Co. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Sept 22, 1955		L. J. DeAlba		James E. Kirkley		Hopping and Kirkley, Glen Burnie, Md.	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

8287

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CHURCH

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

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63. SIGNATURE OF OTHER

64. SIGNATURE OF OTHER

NOT RECORDED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

BUREAU V. 2

SEP 23 1955

RECEIVED

8358

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND <u>Md</u>		STATE <u>Md</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Severna Park</u>		<u>35 yrs</u>		TOWN <u>Severna Park</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>William</u> <u>PAGE</u> <u>Zimmerman Sr.</u>				OF DEATH: <u>9</u> <u>11</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
						<u>July 11, 1887</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>FARMER</u>		9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Baltimore Co. Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Charles Richard Zimmerman</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Scott Seymour</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>--</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-30-5690</u>		17. INFORMANT & ADDRESS: <u>William P. Zimmerman Jr</u> <u>Severna Park Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X IMMEDIATE CAUSE (A) <u>PNEUMONIA</u>						<u>1 wk</u>	
ANTECEDENT CAUSE (S): DUE TO (B) <u>CARCINOMA recto-sigmoid with</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Metastasis to Lungs + Liver</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma Recto-sigmoid with Metastasis to Liver &amp; Lungs</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Sept 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>55</u> , and that death occurred at <u>8:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis J. Cold</u>		ADDRESS <u>M.D. Box 284 Severna Park Md</u>		DATE SIGNED <u>9-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-13-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. J. Tinkner &amp; Sons - Balt 17 Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

